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## **An assessment of the Zimbabwe family planning programme: Results from the 1996 Situation Analysis Study**

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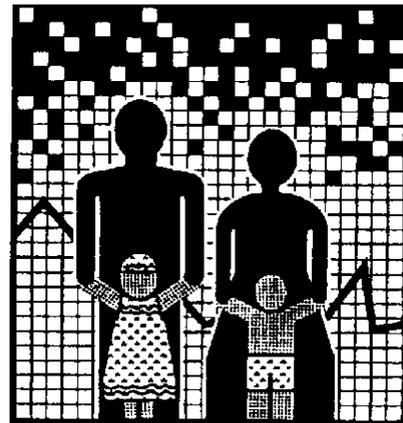
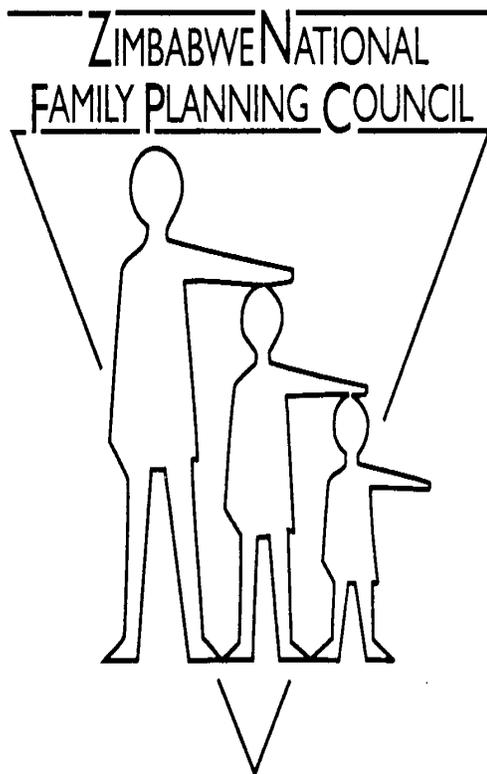
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**AN ASSESSMENT OF THE ZIMBABWE FAMILY PLANNING  
PROGRAMME**  
**Results from the 1996 Situation Analysis Study**



**OPERATIONS  
RESEARCH**  
TECHNICAL ASSISTANCE

**AFRICA PROJECT II**

**THE POPULATION COUNCIL**

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**May, 1998**

## **The Population Council**

*The Population Council seeks to help improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable and sustainable balance between people and resources. The Council analyzes population issues and trends; conducts biomedical research to develop new contraceptives; works with public and private agencies to improve the quality and outreach of family planning and reproductive health services; helps governments to influence demographic behavior; communicates the results of research in the population field to appropriate audiences; and helps build research capacities in developing countries. The Council, a nonprofit, nongovernmental research organization established in 1952, has a multinational Board of Trustees; its New York headquarters supports a global network of regional and country offices.*

### **Africa OR/TA Project II**

The overall objective of the Africa OR/TA Project II is to broaden understanding of how to improve family planning services in Sub-Saharan Africa, and to apply operations research and technical assistance to improve services by:

- increasing access to a full range of family planning services and methods;
- developing service delivery strategies that are client-oriented and acceptable to various population groups;
- improving the operations of programs to make them more efficient and financially sustainable;
- improving the quality of services;
- strengthening the capabilities of family planning program managers to use operations research to diagnose and solve service delivery problems.

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## ABBREVIATIONS

BP	Blood Pressure
CBD	Community Based Distributor
COPE	Client Oriented Provider Efficiency
COC	Combined Oral Contraceptive
ERU	Evaluation and Research Unit
IEC	Information, Education & Communication
IUD	Intra-Uterine Device
FP	Family Planning
GLs	Group Leaders
GTI	Genital Tract Infection
POP	Progestin Only Pill
MCH	Maternal and Child Health
MCH/FP	Maternal and Child Health/Family Planning
MOH & CW	Ministry of Health & Child Welfare
SDP	Service Delivery Point
SDU	Service Delivery Unit
STI	Sexually Transmitted Infection
ZDHS	Zimbabwe Demographic & Health Survey
ZNFPC	Zimbabwe National Family Planning Council
ZSAS	Zimbabwe Situation Analysis Study

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The ZNFPC's Service Delivery, Training and IEC Unit's involvement from the planning stage enabled the study to address relevant programme issues and will facilitate the utilization of the study findings. The ZNFPC's Administration and Finance Unit ensured that the teams received their allowances in a timeous manner and that adequate transport was available for the fieldwork.

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While the ZNFPC acknowledges the support and contributions made by all the above, the ZNFPC is solely responsible for the accuracy of the report and the views expressed therein.

## EXECUTIVE SUMMARY

Within the past 10 years, the Zimbabwe National Family Planning Council (ZNFPC) has conducted two major studies for assessing the availability and quality of reproductive health services. The two studies, generally referred to as Situation Analysis Studies, were conducted in 1991 and 1996.

The 1996 survey collected data from 192 health facilities spread throughout Zimbabwe. During this exercise, an inventory of physical facilities, equipment and educational materials was taken. In addition, 758 provider - client interactions of new and revisit clients were observed. Exit interviews were conducted with service providers, family planning and Maternal and Child Health clients. Wherever possible, findings from the 1996 study are compared to those of 1991 in which 181 health facilities were visited. However, the evolution of the Situation Analysis methodology since 1991 limits the degree to which comparisons can be made between the two studies.

A summary of findings and recommendations from the 1996 study are presented below.

### **A SERVICES AT STATIC HEALTH FACILITIES**

#### **Readiness to provide reproductive health services**

- Over 90 percent of health facilities offered child health, immunisation, growth monitoring family planning and STI services.
- Mission and rural council facilities faced stock-outs of contraceptive methods and supplies. The ZNFPC and municipal clinics were less afflicted with these problems.
- Nearly all health facilities opened on time (between 7:30 and 8:00 am). However, over three quarters of these health facilities saw their first family planning client an hour after opening time. On average, clients waited for just over three quarters of an hour before receiving services.
- Though the largest percentage of clients were served during the morning hours, nearly 60 percent of clinics continued to serve clients in the afternoons.
- Less than a tenth of either FP or MCH clients paid for consultation .
- Health facilities are equipped for methods that they normally provide, including pelvic and speculum examinations.
- Group talks were given at only a quarter of health facilities.
- Posters are the main type of IEC materials found at health facilities. Themes depicted by most posters were on family planning and child health.

- On average, health facilities were supervised once in a month. Though supervisors were reported to examine records (75 percent), inquire about problems (58 percent) and provide supplies (57 percent), a smaller percentage checked equipment or recognized workers' efforts through praise.
- Family planning services were provided by experienced and qualified providers with 89 percent of them stating that they were trained in family planning.

### ***Recommendations for improving facility readiness to provide services***

1. Considering the low percentage of health facilities that conduct group talks, clinic supervisors should be encouraged to make sure that their clinics do so on a daily basis. Health talks can be conducted while clients wait for services to start.
2. It is commendable that an increasing amount of IEC materials has been distributed since 1991. However, the effect of IEC materials on client behaviour needs to be investigated as part of future operations research studies.
3. The frequency of supervisory visits to health facilities is satisfactory, and has improved significantly since 1991. However, the wide variation of activities performed by supervisors shows that there is need for a checklist to be developed and adhered to by supervisors. In addition, a mechanism of feedback to health facilities needs to be developed .
4. Since providers deal with sensitive sexual topics, it is recommended that they should be equipped with communication skills in human sexuality - a skill which was found to be lacking among providers.
5. Apart from health facilities belonging to the Ministry of Health and Child Welfare and municipalities, a fairly large percentage experienced stock-outs of contraceptives and other supplies. It is recommended that these health facilities identify problems associated with these shortages and resolve them.
6. The small percentage of clients who pay for FP and MCH services needs further investigation to establish whether this is a result of inconsistent fee collection practices at health facilities or inability of the vast majority of clients to pay for services. This is important for identifying critical factors in developing sustainable reproductive health programmes.

### **Quality of Care**

- Though a vast majority of both FP and MCH clients were satisfied with services they received, a sizable proportion reported that providers did not attend to their concerns about health and that they had questions which they did not ask.
- The average number of methods providers discussed with new and revisit clients were few; only one and two respectively. Providers told clients mostly about oral contraceptives and the injectable during counseling sessions.

- Between 1991 and 1996, the percentage of clinic providers and CBDs who discussed condoms with clients decreased by 18 and 27 percent respectively.
- Most providers restrict access to FP services by clients based on their ages.
- A high proportion of providers would make appropriate recommendations for women seeking to space and terminate child birth and those with sexually transmitted infections. Only a small percentage of providers demonstrated inaccurate knowledge when they said they would recommend permanent methods for spacing purposes.
- After choosing a method, most new clients were informed about how to use the method, its side effects and how to deal with them. However, many women were not told about the advantages and disadvantages of the chosen method and the possibility of switching to other methods.
- During counseling sessions, IEC materials were found to be underutilized. Contraceptive samples were most frequently used and this was found to be in 90 percent of interactions.
- Procedures observed during pelvic and speculum examinations indicate high levels of technical competence among providers.

***Recommendations for improving quality of services***

1. While clients express high levels of satisfaction with the services received, observations by researchers suggest that the interpersonal skills of some providers could be improved.
2. In order to improve method choice for clients, it is recommended that providers should discuss more methods with new and revisit clients. On average, providers discussed only one and two methods with new and revisit clients, respectively. Providers need to expand discussions to long term and permanent methods instead of concentrating on the injectable and pills only. In particular, the role of the IUD as a long term method needs to be reinforced since its use has not changed since 1991.
3. In view of the high incidence of HIV/AIDS in the country, both clinic service providers and CBDs should be encouraged to discuss condoms with clients routinely.
4. Despite workshops conducted to reduce barriers to contraceptive access, providers continue to impose restrictions based on the age of the client, marital status, spousal consent and number of living children. A more concerted effort in disseminating the latest policy guidelines at regional and facility levels is recommended.
5. Though a large percent of women are informed about how to use the contraceptive methods chosen and expected side effects, a far smaller percentage is told about how to deal with problems associated with the method and the possibility of switching to other methods. This aspect of counseling needs to be reinforced among service providers.

6. During health talks and counseling sessions, providers should be encouraged to use IEC materials.

### **Sexually Transmitted Infections**

- Nearly 60 percent of providers reported that they had attended refresher or post basic courses that included counseling and management of STI/AIDS.
- Diagnosis of STIs was based on the syndromic approach. In nearly all health facilities, managers reported that counseling services for AIDS and STIs and treatment for STIs were provided.
- Tests for gonorrhea, chlamydia, candida and HIV were available in less than a tenth of health facilities. Referrals to other health facilities with these testing services were also low.
- Most health facilities had a reasonable range of supply of first line and second line commonly used drugs for the treatment of sexually transmitted infections.
- Over half of MCH and FP clients knew that lesions or sores are common signs of STIs. A far smaller proportion of clients were likely to associate abnormal vaginal bleeding, genital itching, warts, urethral discharge, painful urination and painful intercourse with sexually transmitted infections.

### ***Recommendations for integrating STI services***

1. Although a high percentage of providers stated that they were trained in the syndromic approach for screening clients for sexually transmitted infections, actual observations showed that these procedures were infrequently done. Service providers should be encouraged to use the approach on a regular basis to screen clients for sexually transmitted infections.
2. Since 1995, due to reduction of medical barriers, providers have not been routinely required to conduct medical and pelvic examinations for clients, and yet their assessment of STIs based on the syndromic approach is infrequent. It is recommended that some other measures should be put in place to strengthen providers' skills and ability to diagnose sexually transmitted infections.
3. In view of the extensive reliance of providers on the syndromic approach, the reliability of this method needs to be assessed against the laboratory based techniques.
4. The wide variation of actions that providers say they would take for clients infected with STI or HIV suggests a lack of standard procedures on how they should deal with these clients. STI programmes need to address these issues during their training.
5. Though over a half of clients mentioned lesions and sores as common signs of sexually transmitted infections, in general, their knowledge of other symptoms is low and this is an area of intervention for public health education for family planning and STI programmes.

Further research needs to be conducted to identify and understand clients' definitions and views of sexually transmitted diseases.

6. It is encouraging that nearly all clients knew about HIV/AIDS and that it is transmitted mainly through sexual intercourse. However, it is important for reproductive health programmes to emphasize other modes of HIV transmission. For example, couples with at least one partner infected need to make informed decisions about having children in light of the evidence about vertical transmission of the virus.

## ***B THE CBD PROGRAMME***

### **Preparedness to deliver services**

- CBDs continue to devote most of their time to attending revisit clients than initiating new clients.
- The quality of contraceptive kits, checklists and record books were reported to be poor; hence some of the CBDs do not carry these items as they are expected to.
- Distribution of IEC materials to the CBD sector is very limited and CBDs do not appear to be adequately trained in their use.
- A fairly large proportion of group leaders did not routinely check on CBD stocks, equipment and record books.

### ***Recommendations for improving the CBD preparedness to deliver services***

1. CBDs continue to devote most of their time to revisit clients instead of initiating new ones and this may suggest that the current catchment areas served by CBDs are saturated. Strategies need to be developed to expand to new areas while maintaining services in the existing CBD areas. Alternatively, the role of CBDs may need to be revised.
2. The quality of sample kits, checklists and record books should be improved. For example these materials can be laminated to improve durability.
3. In view of the limited distribution of IEC materials to the CBD sector, there is need to develop good quality and relevant visual materials for distribution.
4. Group leaders need to use the supervisory checklists so that they routinely check CBD stocks, equipment and record books.
5. Since a fairly large proportion of CBDs (42 percent) felt that their basic course is inadequate, the trainers need to investigate topics that need attention for the CBDs to execute their duties confidently.

### **Quality of Service Delivery among CBD workers**

- Clients were given limited information on condoms and long term methods.
- Use of IEC materials during counseling was scantily done.
- CBDs knew only a few signs and symptoms of STIs and this also applied to their clients.
- A sizable proportion of both CBDs and their clients had used vaginal preparations; a practice associated with some cancers and increased risk of sexually transmitted infections.

### ***Recommendations for strengthening the quality of care in the CBD programme***

1. Although most CBDs used the contraceptive checklist during client interactions, it was observed that their counseling skills were generally weak. In particular they needed more information to counsel client on condoms, long term and permanent methods.
2. Considering that only a few signs and symptoms of STIs are known by CBDs, the ZNFPC should include topics on STI counseling skills for the CBD training programme.
3. There is need to educate both CBD agents and the public about the health risks associated with use of vaginal preparations.

# I THE ZIMBABWE FAMILY PLANNING PROGRAMME

## A INTRODUCTION

The 1994 Zimbabwe Demographic and Health Survey (ZDHS) shows that knowledge of family planning methods is almost universal and the contraceptive prevalence rate for modern methods of contraception has increased from 27 percent to 42 percent from 1984 to 1994.<sup>1</sup> Although the Zimbabwe family planning programme is considered one of the success stories in Sub-Saharan Africa, there is still an unmet need and demand for family planning services. The 1994 ZDHS calculates that ten percent of all women have an unmet need for family planning services. The same study calculated that nine percent of currently married women had an unmet need for spacing while six percent had an unmet need for limiting births. Moreover, almost two-thirds of currently married women non-users said that they intend to use family planning methods in the future. These figures present a challenge for the Zimbabwe family planning program.

The same study also revealed that Government-sponsored static health facilities and Community Based Distributors remain the chief source of modern contraceptive methods in Zimbabwe. Approximately 85 percent of current users obtain their method from public sector sources.<sup>2</sup> Thirty-two percent of women using contraceptives obtained their methods from rural/municipal clinics, 30 percent from government hospitals/clinics including rural health centers, mission facilities and mobile clinics, 23 percent from the ZNFPC Community Based Distributors (CBDs) and clinics, 12 percent from private sector<sup>3</sup> and 3 percent from other sources such as, friends and relatives.

Although most clinical Service Delivery Points (SDPs) are run by the MOH&CW or the municipalities, the family planning programme is coordinated by the ZNFPC, which was established as a parastatal organization in 1985. The ZNFPC procures all the family planning commodities for the public sector and, until recently, was in charge of all the training of family planning service providers.

Despite the constrained budget resources, government and international donor support has provided the ZNFPC with resources to maintain an extensive network of field workers, clinics and a coordinating role for the services throughout the country. The programme has also received considerable support from international donors in terms of training, equipment, supply of contraceptives, and financial support for projects.

In planning its activities, the ZNFPC follows a five year planning cycle for its strategic plans; the first five year cycle came to an end in 1996. Since 1997, the ZNFPC has been developing the

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1 *Zimbabwe National Family Planning Council (ZNFPC) and Westinghouse Public Applied Systems. 1985. Zimbabwe Reproductive Health Survey 1984. Columbia, Maryland; ZNFPC and WPAS; Central Statistical Office (CSO) [Zimbabwe] and the Institute for Resource Development/Macro Systems Inc. (IRD). 1989. Zimbabwe Demographic and Health Survey 1988. Columbia, Maryland; Central Statistical Office(CSO) [Zimbabwe] and the Institute for Resource Development/Macro Systems Inc. (IRD). 1995. Zimbabwe Demographic and Health Survey 1994. Columbia, Maryland.*

2 *Central Statistical Office and Macro International Inc. 1995. Zimbabwe Demographic and Health Survey, 1994. Calverton, Maryland: Central Statistical Office and Macro International Inc.*

3 *There was an increase in the proportion of current users who obtain their methods from the private sector from about four percent in 1988 to 12 percent in 1994 (ZDHS).*

second strategic plan for 1997 to 2002. The plan is crucial for the ZNFPC as it provides the organisation and others involved in the delivery of family planning and other reproductive health services with a clear guidance for organizing, managing, administering and evaluating family planning activities. In addition, the strategy provides a framework within which the Government and donor agencies can organize their funding levels and allocations.

## ***B SUMMARY OF ZNFPC'S PROGRAMME INTERVENTIONS BETWEEN 1991 AND 1996***

The ZNFPC has four programme units which oversee service delivery, training and information, education and communication (IEC) and research. A brief description of activities undertaken in the Service Delivery, Training and IEC Units during the Council's first strategic plan (1991 - 1996) follows.

### **1 Service Delivery**

In line with the goal to widen the method mix, the ZNFPC advocacy efforts paid off when the MOH&CW removed the restrictive criteria for the provision of the depo provera injectable. Following the lift of the ban in June 1992, the Service Delivery Unit (SDU) of the ZNFPC conducted a number of update workshops to refresh providers on all the contraceptives with particular attention paid to the injectable. Similar workshops to disseminate new guidelines to eliminate provider restrictions based on age, marital status, spousal consent and parity were held throughout the country.

In order to make ZNFPC clinics more cost-effective, those located within the Ministry of Health facilities were closed down since the latter already had functional Maternal and Child Health and Family Planning (MCH/FP) Units. In response to the 1991 Zimbabwe Situation Analysis Study (ZSAS) findings that some facilities did not have the necessary equipment for FP service delivery, the Unit facilitated the procurement and distribution of equipment to facilities. The establishment of a Logistics Unit at ZNFPC in 1993 has also helped in facilitating a systematic procurement, storage and distribution of contraceptive supplies and equipment. For example, all the ZNFPC CBDs now have Aneroid Blood Pressure (BP) machines.

The 1991 ZSAS study found that CBDs were spending most of their time re-supplying clients, instead of recruiting new clients. Service statistics were showing that the programme was becoming too costly to maintain and this led to the piloting of a community based depot holder model in two districts of the country. The project was designed so that clients would use depot holders as sources of contraceptives for resupply purposes while the CBD agents concentrated on recruiting new clients.

### **2 Training Activities**

After the 1991 ZSAS, the Training Unit revised the family planning training curricula taking into account the deficient areas identified in the survey. The 1991 study highlighted that counseling skills for both the nurses and CBDs were weak and this was based on the limited information exchange that was observed during their interactions with clients. The production of materials for training providers in counseling and interpersonal communication modules was

delayed and this resulted in a limited number of providers being trained during the first five year strategy.

During the 1991-1996 ZNFPC strategic plan, the unit's output of trained family planning providers was enhanced through: i) the decentralised training at MCH/FP schools in selected districts; ii) the inclusion of FP module in basic nurse training; and iii) the decentralisation of FP in-service training to City Health Departments. In particular, the ZNFPC responded to the findings from the 1991 ZSAS that the provision of IUDs was limited and that providers hardly discussed or provided STI services by developing a module which integrated the diagnosis and management of genital and urinary tract infections. Furthermore, the Training Unit piloted an on-the-job-training programme in IUDs and screening for genital tract infections.

The provision of long term methods such as implants and permanent methods was considered an important component of the strategy and thus this was initiated during this period. In this regard, the Training Unit of the ZNFPC started private sector programs where teams of doctors and nurses were trained in the provision of long term and permanent methods.

### **3 IEC Activities**

Since 1991, the IEC Unit has embarked on a number of activities to increase demand for long term and permanent methods. High quality materials were developed and produced for trainers, service providers, clients and the general public. Some sites were selected and the IEC Unit assisted in the training of service providers in interpersonal, communication and counseling skills. Advocacy initiatives and male motivation campaigns were conducted to solicit political, financial and administrative support for reproductive health and family planning activities. Pilot programmes to encourage responsible sexual and reproductive health behaviour among youth were initiated towards the end of the 1991 - 1996 ZNFPC Strategy.

The implementation of the 1996 ZSAS was important for several reasons. The study served as an evaluation and measure of changes after interventions were introduced in the 1991 to 1996 five year strategy. In preparation for the second strategic plan, the ZNFPC needed baseline data to use and the second Situation Analysis provided this information.

## II STUDY METHODOLOGY

### A *STUDY OBJECTIVES*

#### 1 **Ultimate Objective**

To strengthen the subsystem functioning and improve the quality of care provided by the Zimbabwe family planning programme.

#### 2 **Immediate Objectives**

- i) To provide information on the constraints and weaknesses in family planning subsystems including logistics/supplies, physical facilities, staffing, training, supervision, IEC and record keeping that will be used to develop the next five-year country strategy for Zimbabwe.
- ii) To assess changes in subsystem functioning and quality of care in the Zimbabwe national family planning programme since the baseline study conducted in 1991.

### B *SAMPLING*

#### 1 **Static Clinics**

To allow for comparability, the same clinics were sampled in the 1991 and 1996 Situation Analysis studies. Adjustments were made for the sample sizes in the provinces of Matabeleland South and Midlands where some facilities could not be visited in 1991 because of the security situation in those provinces. Except for facilities that belonged to the ZNFPC, the rest (Ministry of Health, mission, municipal) were selected so that the numbers were proportionate to the total number of health facilities in each of the eight provinces and the number for each of the administrative authorities managing them. All the ZNFPC facilities were included in the study. Table 1 shows the distribution of health facilities for the 1991 and 1996 Situation Analysis surveys.<sup>4</sup>

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<sup>4</sup> *The Zimbabwe National Family Planning Council, the Population Council's Africa OR/TA Project and the Family Planning Service Expansion and Technical Support Project A Situation Analysis of the Family Planning Programm, 1992. Harare. Zimbabwe.*

**Table 1: Distribution of Sampled Facilities by Province for the 1991 and 1996 Situation Analysis Studies**

Province	Number of Health Facilities	
	1991	1996
Manicaland	39	38
Mashonaland Central	14	15
Mashonaland East	26	29
Mashonaland West	23	27
Matabeleland North	19	18
Matabeleland South	3	17
Midlands	37	26
Masvingo	20	22
Total	181	192

## 2 Community Based Distributors

The same sampling plan used in 1991 was adopted for selecting CBDs in the 1996 survey and therefore, the same CBD catchment areas were visited during the two surveys. As far as possible, the CBDs that were sampled in 1991 were included in 1996 to allow for reasonable comparison between the two studies. In order to interview the expected number of CBDs, 19 Group Leaders were sampled and data was collected from all the CBDs supervised by the sampled Group Leaders. Though there had been an increase of approximately 21 percent in the number of CBDs since 1991, there were no adjustments in the sampling plan. Table 2 shows the number of CBDs used as study units for the two surveys.

**Table 2: Distribution of Samples of CBDs by Province for the 1991 and 1996 Situation Analysis Studies**

Province	Number of CBDs	
	1991	1996
Manicaland	27	20
Mashonaland Central	18	10
Mashonaland East	11	10
Mashonaland West	18	12
Matabeleland North	19	16
Matabeleland South	7	6
Midlands	19	10
Masvingo	21	14
Total	140	144

## **C DATA COLLECTION INSTRUMENTS**

The basic data collection instruments were based on the standard Situation Analysis Study instruments which have been developed and tested in a number of countries.<sup>5</sup> A three-day planning workshop was conducted in Harare to review the standard instruments and customize them to the Zimbabwean needs. Participants to the workshop were drawn from ZNFPC, MOH&CW, Harare and Bulawayo City Health Departments.

The Zimbabwe family planning system is based on two main modes of service delivery; static health facilities and community based distributors. The Situation Analysis approach requires that at each service delivery point visited, information is collected through observations, interviews and a facility inventory. Two major methods were used to collect data; structured interviews with providers and clients, observations of clinic conditions and provider/client interactions. The instruments used to collect data during the study are listed below.

### **1 Data Collection Instruments for Static Clinic Health Facilities**

- Inventory of facilities available and services provided at the health facility;
- Interview schedule for staff providing family planning, maternal and child health (MCH) services at the health facility;
- Observation guide for interactions between consenting family planning clients and service providers;
- Exit interviews for consenting family planning clients;
- Questionnaire for female MCH clients attending the health facility.

### **2 Data Collection Instruments for CBDs**

- Interview schedule for Group Leaders;
- Interview schedule for CBDs on services provided and inventory of equipment/items they carry;
- Observation guide for interactions between consenting family planning clients and CBDs;
- Exit interviews for consenting family planning clients.

### **3 Research Teams**

Interviewers were selected according to their previous experience and sensitivity for this type of work and were given detailed and intensive training immediately prior to the field work. Training in the collection and interpretation of the data using the Situation Analysis (SA) approach has become standardized through the development of a set of core data collection instruments, training manuals and analysis guidelines. Training included reviewing the instruments, role playing and pretesting the instruments. Field visits required careful organization in order for all the selected health facilities to be visited. A senior member of each of the teams was designated as a Team Leader for the group. Data was collected during 25

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<sup>5</sup> Miller, R., Andrew Fisher et al (1997) *“The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook.”* Population Council, New York.

working days over a period of six weeks. On average, each team was expected to conduct interviews at 25 health facilities, thus spending one day at each facility.

There were eight research teams each consisting of four interviewers, with at least 2 of them having a nursing background. Each team visited a cluster of health facilities that were relatively close to each other to ensure the most efficient use of transportation. At static health facilities, one member of the team interviewed staff and reviewed records, the other member observed provider-client interactions and the third member interviewed some or all the exit clients observed that day. The fourth member of the team was responsible for collecting data from the CBD agents operating within the catchment area of the health facility.

#### ***D SAMPLE CHARACTERISTICS***

From 192 sampled health facilities, 759 women were observed while they received services from providers. From these observations 746 women agreed to be interviewed at their time of exit. Most of the clients (72 percent ) who visited health facilities were revisit clients while the rest were new or restarting use of contraceptives after a break of more than six months. A total of 1313 MCH clients were also interviewed as they left the health facilities. Group leaders and CBDs who operated within the catchment areas of CBDs were sampled. Using this scheme, 19 group leaders who supervised a total of 144 CBDs were sampled. Both the group leaders and their CBDs were interviewed. In addition, the CBDs were observed while they interacted with their clients. A summary of the samples for different categories of clients are shown in Table 3. Discussions of the research findings in the following chapters are based on these sample sizes

**Table 3: Distribution of Sample Characteristics for the 1996 Situation Analysis Study**

<b>Type of Sampled Unit</b>	<b>Number of Cases</b>
Health facilities	192
FP Observations	759
FP Exit Interviews	746
Service Providers interviewed	376
MCH Clients	1313
Group Leaders	19
CBD interviews	144
CBD-client interactions	641
Client Exit	635

### III KEY FINDINGS FOR THE CLINIC BASED PROGRAMME

The findings for the clinic-based family planning programme have been grouped under four headings, namely:

- A Access to reproductive health services
- B Functioning of the health facility sub-systems
- C Quality of care at health facilities
- D Provision of Sexually Transmitted Infection services

#### A ***ACCESS TO REPRODUCTIVE HEALTH SERVICES***

Access to family planning and other reproductive health services was measured in terms of the following:-

- availability of services
- times when services are available to clients
- clients' travel, waiting times and facility opening times
- cost of services to clients

#### 1 **Availability of FP and Reproductive Health Services at Health Facilities**

Facility managers were asked what services their facilities usually provided.<sup>6</sup> Health facilities provided an array of services consistent with the integrated health policy promoted by the Ministry of Health and Child Welfare since the 1980s. Through this policy, a client is expected to receive a wide range of services at the MCH/FP units without having to go to other Units of the facilities. Nearly all health facilities were reported to provide family planning services and this was expected since the sample targeted health facilities that provide these services. Child health services such as immunization and growth monitoring were offered by close to 90 percent of health facilities. Maternity and post natal care services were offered in at least three quarters of health facilities while STI services were reported to be offered at 94 percent of MCH/FP Units.

Reports from managers of health facilities present a picture of highly integrated services at the MCH/FP units. Responses showed that these services were available not only at the MCH/FP Units, but also elsewhere at the health facilities, for example, the curative departments.

#### 2 **Availability of Contraceptive Methods**

Popular contraceptive methods such as oral contraceptives, the injectables and condoms were provided at over 90 percent of health facilities. The IUD was provided at less than a fifth of the

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<sup>6</sup> *Usual availability was investigated as opposed to current availability in case of those services not available only on the day of the study.*

health facilities. Further, contraceptive stock-outs varied according to organisations running the health facilities (Table 4). The ZNFPC and Municipal health facilities were found to be least affected by stock-outs of contraceptives. Mission and rural council facilities looked particularly susceptible to shortages.

**Table 4: Percent of Facilities Usually Providing Method and Experienced Stock-Outs in the last six months (N=192)**

Sector	Stock-outs in the last 6 months at facilities offering method				
	COC	POP	Condom	Injectable	IUD
MOH&CW	17	19	31	31	20
ZNFPC	0	0	0	5	5
Mission	15	31	31	31	0
Municipality	7	7	0	8	0
Rural Council	20	26	36	34	0
Other	38	13	0	13	100
National	16	19	26	27	13

### 3 Clients' Travel, Waiting and Facility Opening Times

On average, family planning services were offered at facilities for 6 days per week. Though over 90 percent of health facilities opened for services between 7:30 and 08:00 am, over three quarters of them served their first family planning clients after nine o'clock. The largest percent of clients were served during morning hours but nearly 60 percent of clinics registered family planning clients after 2'oclock in the afternoon. It can be concluded that providers serve FP clients throughout the working hours. Asked about how they valued services, about 90 percent of both family planning (FP) and maternal and child health (MCH) clients felt that opening times were convenient for them.

The mean estimated travel time to facilities by FP and MCH clients was 53 minutes and 58 minutes respectively. The majority of FP and MCH clients walked to facilities. Furthermore, no marked differences in waiting times were observed for FP and MCH clients, with mean estimated waiting times estimated at 51 and 49 minutes respectively.

### 4 Cost of Commodities/Services to Clients

Health services in Zimbabwe's public sector are free to clients who earn a monthly income of less than Z\$400.00 (US\$35.40). Table 5 shows that a small percent of women paid for consultation, drugs and registration (note book). For family planning clients, the greatest proportion paid for contraceptives. The largest percent of MCH clients incurred travel expenses. The overall cost was considered acceptable to 88 percent of FP clients and 60 percent of MCH clients who paid for services.

In view of discussions about recovering costs for services at health facilities, the small percentage of clients who paid for services presents a grim picture. The data may be interpreted to mean that the majority of clients are unable to pay for different components of family planning and MCH services because their incomes are below the Government's limit of Z\$400. In that case, to increase revenue will depend on identifying alternative sources. Secondly, the data may be revealing a situation of inconsistent fee collection at health facilities in which case this component of management may need strengthening.

**Table 5: Median Cost of Services and Commodities Bought by Clients During Day of Study (FP clients N=746, MCH clients N= 1313)**

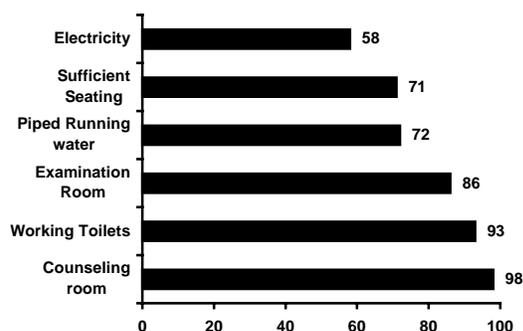
Commodities	Family Planning Clients		MCH Clients	
	% Paid	Median Cost Z\$	% Paid	Median Cost Z\$
Consultation	5	7.40	7	12.40
Drugs	2	6.60	2	4.00
Note book	2	3.50	8	1.40
Travel	17	2.00	12	2.25
Contraceptives	36	2.50	--	--
Other	2	7.00	--	--
Average Cost	--	4.80	--	--

## ***B FUNCTIONING OF HEALTH FACILITY SUBSYSTEMS***

### **1 Physical Infrastructure Available**

Data on the availability of the basic infrastructure were collected in terms of piped running water, electricity, working toilets, seating space, counseling and examination rooms (Figure 1). Findings revealed an expected pattern; most health facilities had working toilets, counseling and examination rooms. Piped water and electricity were less available especially in rural health facilities. Due to overcrowding in a number of health facilities, more than a quarter of them were judged to be without sufficient seating space.

**Figure 1: Percentage of Facilities With Specific Infrastructure (N=192)**



## 2 Availability of Equipment for Providing FP Services

For many contraceptive methods, equipment availability is a prerequisite for proper service delivery. Figure 2 shows that, for most equipment required *for general delivery of family planning services*, there was overall improvement of availability in 1996 compared to 1991. Slight declines in availability were noted in the case of sterilizing equipment, uterine sounds and tenacular located at the MCH Units. These changes are viewed as a result of sampling fluctuations rather than real changes in availability.

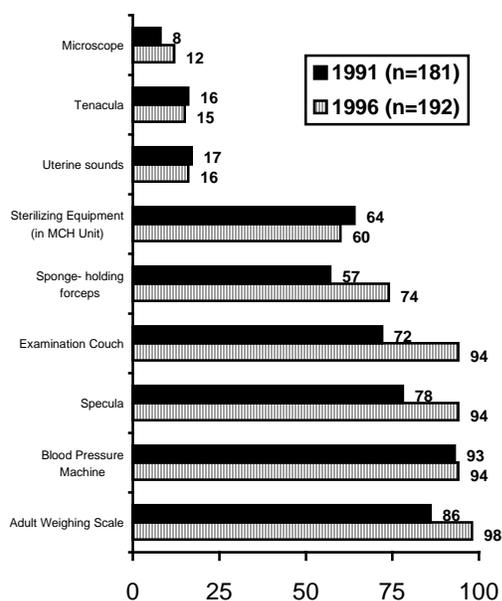
In the 1996 Situation Analysis Study, most MCH/FP Units were found to be well equipped with a wide range of equipment. Nearly all health facilities were found to have sterilizing equipment, gloves and supplies. In the previous five years, health facilities showed a shift from using non-disposable gloves to using disposable ones.

For example, the median number of disposable gloves (205) found at health facilities was far higher than that of non-disposable gloves (60). The shift to using disposable gloves indicates an increased effort paid to infection prevention as the Government responds to the rising incidence of sexually transmitted infections and HIV/AIDS in the country. The general availability of sterilizing equipment, lotions and gloves is a commendable situation expected to improve service quality at health facilities.

## 3 Equipment for Provision of the IUD

Considering the ZNFPC's goal of broadening the method choice for clients as stated in the 1991-1996 strategic plan, the low percent of health facilities that normally provided the IUD should raise some concern. Less than a fifth of health facilities stated that they usually provide the method. For the facilities that performed the insertions, the majority had equipment, supplies and the method in stock (Figure 3). Further, the study revealed that the largest percentage (61 percent) were ZNFPC clinics followed by district hospitals (13 percent). The rest of the facilities were spread evenly between the central, district and mission hospitals, municipal, town and rural council clinics.

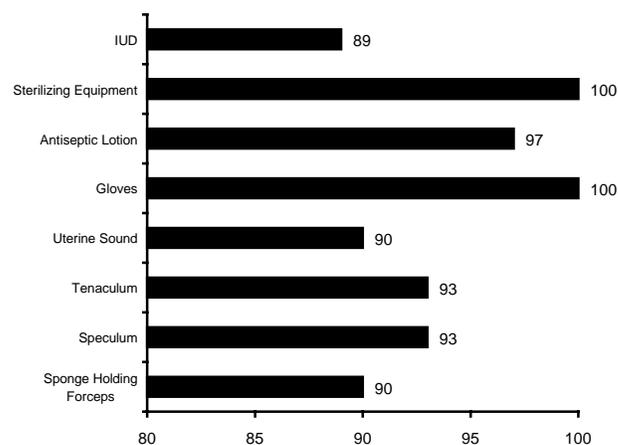
**Figure 2: Percentage of Facilities With Particular Equipment for MCH/FP Services**



The low percent of health facilities that were in a position to offer the IUD is comparable to the results shown in the 1991 Situation Analysis Study. Of the 181 facilities that were visited in 1991, only 17 percent were found to have the CU T380A. Other types of IUDs were far less available. From these figures, it can be concluded that the program has made limited progress in expanding the use the IUD method.

Though only 16 percent of Zimbabwean facilities were found to offer IUDs, most of them were well equipped with equipment to conduct general and pelvic examinations. As indicated earlier, equipment for general examinations, that is, blood pressure and weighing machines, thermometers and stethoscopes were available in the majority of health facilities. This was found to be the case with equipment for pelvic examinations (sterilisers, gloves, antiseptic lotions, examination couches, specula and gloves).

**Figure 3: Percent of Facilities Providing the IUD and with Equipment and Supplies for Insertion (n=31).**



#### **4 IEC Activities**

In order to generate demand for family planning services and keep clients well informed about reproductive health issues, information to clients is disseminated using various media such as group talks, posters and take-home print materials. For a few facilities, radios and/or televisions are also used to disseminate MCH/FP information. A description of findings about the implementation of IEC activities at health facilities follows.

##### *i Group talks*

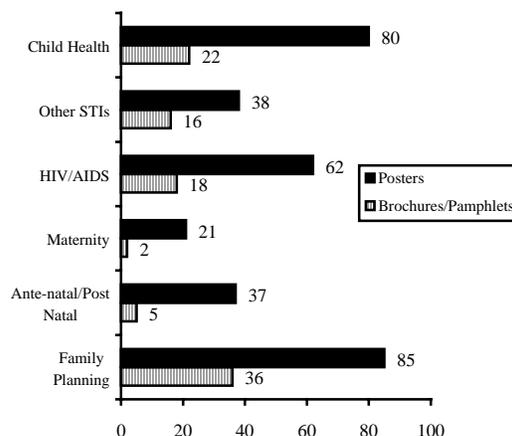
Health workers are encouraged to deliver talks to clients when facilities open in the morning. Group talks were held at 25 percent of the facilities visited in 1996 compared to 15 percent reported in 1991. Topics covered at ZNFPC clinics were all on family planning and this is expected since that is the specialization of these clinics. On the other hand, group talks at non-ZNFPC health facilities covered a wider range of topics; namely, immunization (43 percent), nutrition (20 percent), ante-natal/post natal care (19 percent), child growth monitoring (15 percent), maternity services (13 percent) and breast-feeding (11 percent).

##### *ii Availability of IEC materials at facilities*

Except for the Harare City Health Department which has its own production unit, other sectors depend on IEC materials produced by the Audio Visual Unit (AVU) at the ZNFPC. Though the function of the AVU is to produce FP and MCH materials for the ZNFPC and the Ministry of Health, these materials are distributed beyond these two sectors.

Different types of IEC materials were found at health facilities but posters were most dominant, followed by brochures and flip charts. In 1991, 55 percent of health facilities had family planning posters and the data for 1996 shows an increase of over 30 percent. Availability of pamphlets or brochures showed an increase of over 15 percent between the two study periods. As expected, radios and video cassettes were least available. For both brochures and posters, the themes that were most frequently portrayed were family planning, child health and HIV/AIDS. Figure 4 shows the themes illustrated by brochures and posters found at health facilities. Though IEC materials depicting themes on antenatal care, maternity and sexually transmitted diseases were found at some health facilities, they were not common.

**Figure 4: Percentage of Facilities with Each Type of IEC Materials Available (n=192)**



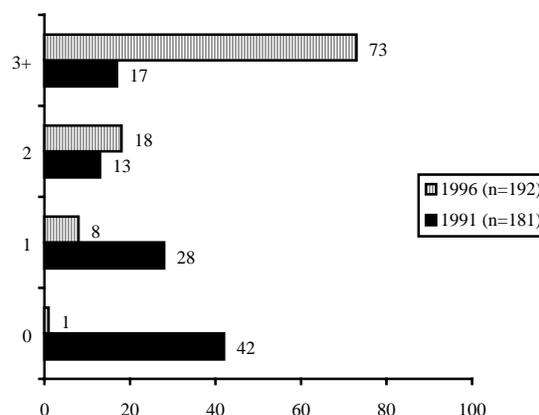
Though there has been an increase in the percentage of health facilities giving health talks since 1991, the figures are still low. Considering the cost of producing IEC materials, health talks at facilities still offer a relatively cheap way of educating women on health issues. It is commendable that an increasing amount of IEC materials have been distributed since 1991. However, the effect of IEC materials on client behavior needs to be investigated as part of future operations research activities.

## 5 Supervision

Family planning services in Zimbabwe are supervised by both the ZNFPC and the MOH & CW. Supervisors from these two sectors provide support to other sectors. On average, facilities were visited by supervisors six times during the six months preceding the study (approximately, once per month).

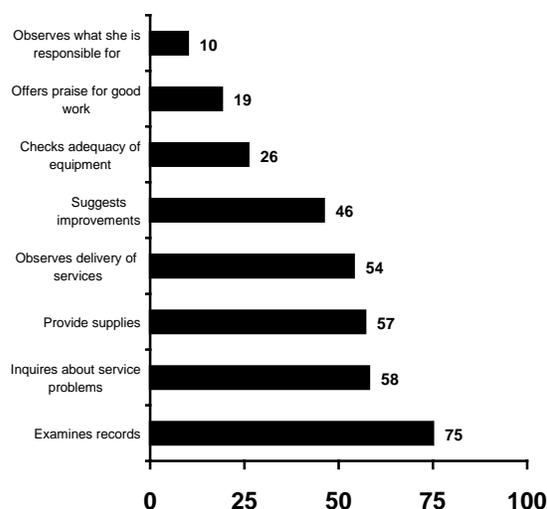
Figure 5 confirms the observation that supervisory visits improved significantly between 1991 and 1996. While 42 percent of health facilities reported that they had no supervisory visits in 1991, the figure decreased to only one percent in 1996. Though the Ministry of Health and Child Welfare conducts most of the family planning supervision, 36 percent of the facilities had been visited by ZNFPC personnel. This collaborative effort in supervising family planning services should be encouraged and perhaps used as a model with other sectors.

**Figure 5: Number of Supervisory Visits to Health Facilities Six Months before the Survey (1991 and 1996)**



The wide variation among the activities taken by supervisors indicates a lack of consistency in what they do during their visits (Figure 6). By far, the three most popular actions taken by supervisors during visits are examination of records, inquiry about service problems and delivery of supplies. It is commendable that over half of supervisors observe the delivery of different services and at the same time it is surprising that just about a tenth were reported to observe services that they are responsible for. The integration of supervisory functions should be encouraged in order to minimize costs.

**Figure 6: Activities Executed during Supervisory Visits (n=192)**



## 6 Staff Training and Experience

The majority of service providers at health facilities were found to be nurses, with just over a quarter of them also working as nurse aides. As expected, medical and clinical officers were found in a few hospitals.

The 1996 survey found that family planning providers were experienced and well trained with eighty-nine percent of them stating that they had received FP training either during their basic (66 percent) course or post-basic (23 percent) training. The decentralization of the in-service MCH/FP training to districts and city health departments' training schools has significantly contributed to the increase of trained providers. The small percent of providers who had not received any FP training were more likely to be located at rural health centers.

Table 6 shows the wide range of FP and clinic management courses attended by providers during post-basic or refresher training. Of the 376 providers, 52% had attended refresher courses. It is noticeable that a high percent of providers attended refresher courses in general clinical skills and family planning counseling. The limited proportion of providers who had undergone training in the insertion and removal of IUDs, implants and permanent methods is consistent with the low percentage of facilities offering these methods. Further, the table shows that a small percentage of providers received training in basic communication skills and this may partly account for the small percentage of providers who were found to discuss topics on sexuality and condom use with clients.

Overall, the 1996 results show that a higher percentage of providers were trained in family planning courses compared to 1991. In 1991, six percent of providers had attended FP refresher courses and this figure jumped to 60 percent in 1996. Service providers who were trained in IUD insertion and removal also increased significantly from nine percent to 34 percent. All these changes taken show tremendous progress that has been made between 1991 and 1996. Despite this progress, the program lags in providing adequate IEC skills to providers and this area needs attention.

**Table 6: Percentage of Providers Who Had Attended Refresher Courses by Type of Course (n=194 )**

<b>Content/Topic</b>	<b>% of Providers</b>
General FP clinical skills	87
FP counseling	83
IUD insertion /removal	34
Implants insertion /removal	19
T/L ML/LA	44
Vasectomy	46
Natural Family Planning (NFP)	75
Supervision of FP services	69
Record keeping	80
Stock keeping	78
Basic IEC skills	32
Human sexuality & communication skills	25

## **7 Commodities Management**

Over three-quarters of service providers stated that they had received training in clinic and stock management. These results may account for the high proportion of facilities which were evaluated to have well written and up-to date inventories. Nearly all facilities had adequate storage facilities and commodities were stored according to expiry dates. An improvement in

commodity management in terms of correct stock keeping from 62 percent in 1991 to 93 percent in 1996 was noted.

## **8 Client Records**

The majority (80 percent) of service providers reported that they had been trained in record keeping and this may explain the finding that 60 percent of the facilities had well ordered and systematically filed record cards. The training of providers in record keeping and the attention supervisors pay to this aspect of their job may partly account for the well-judged state of records. It is suggested that supervisors should verify the validity of the records as the next step towards improving their quality.

Health facilities were found to use different systems for keeping clients' records. For the majority of health facilities (53 percent), clients kept their records; for 26 percent both the clients and facilities kept the cards and for 18 percent only the clinic kept the clients' cards. The remainder of facilities had no clear card system and these belonged to the Ministry of Health and Child Welfare.

### ***C QUALITY OF CARE AT STATIC HEALTH FACILITIES***

The following discussion on quality of care for family planning services is based on the six elements proposed by the Bruce-Jain framework for the assessment of family planning service quality. The six elements are interpersonal relations, method choice, information given about the method, technical competence, integration of other health services and the mechanisms for promoting contraceptive continuity.<sup>7</sup>

During the 1996 ZSAS, a total of 758 client observations were made. Twenty-eight percent of the clients were new/restart clients; 59 percent had come for resupply and 13 percent had problems with the method or wanted to switch or discontinue contraceptive use. The most popular method among revisit clients was the injectable used by 37 percent of them, followed by combined oral pills (31 percent) and progestin only pills (24 percent). Of the remaining clients, some were using the IUD or Norplant implants (three percent) and others had stopped the method before the revisit (five percent) date. For comparison purposes, 210 observations of new and restart clients from the 1996 study are compared to 214 similar cases drawn from the 1991 study. The observation instrument has expanded significantly since 1991 and, to an extent, this limits the scope of comparisons between the two surveys.

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<sup>7</sup> Bruce, Judith, "Fundamental Elements of the Quality of Care: A Simple Framework," *Studies in Family Planning*, 21:2, 1990; S Kumar, A. Jain & J Bruce. *Assessing the Quality of Family Planning Services in Developing Countries. Programs Division Working Papers No.2*, The Population Council, New York, 1989.

## 1 Interpersonal Relations

Consistent with similar surveys in the region, and attributed to courtesy bias, clients reported high levels of satisfaction with services received from health facilities.<sup>8</sup>

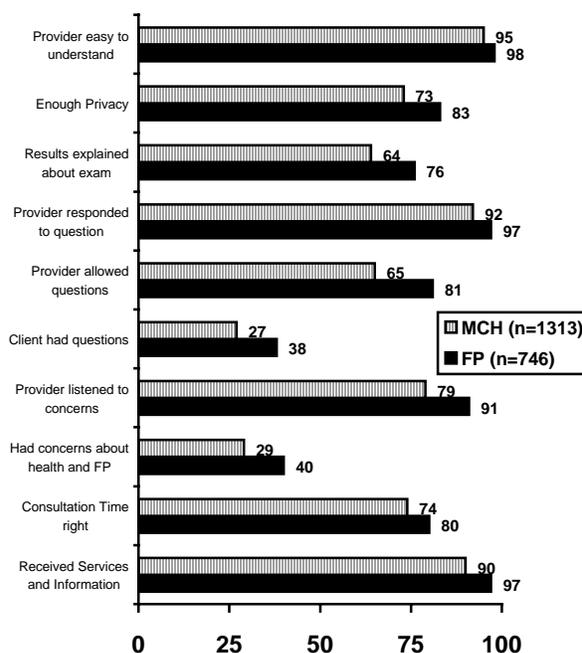
Both MCH and FP clients reported that the providers were easy to understand and that they received the services and information that they wanted. Though there is no plausible explanation, a larger percentage of family planning clients expressed satisfaction compared to MCH clients. The indicators for which measures were available are shown in Figure 7. For example, a greater proportion of FP than MCH clients reported that providers listened to their concerns, allowed them to ask questions and responded to the questions satisfactorily. In addition, 83 percent of FP clients reported that they felt they had enough privacy during their consultation compared to 73 percent of MCH clients. Among the MCH women, those who visited for antenatal, maternal, postnatal, curative, infertility and sub-fertility services, were more likely to report that their consultation was conducted privately compared to those who had come for child care, respectively 87 and 63 percent. This suggests that providers are aware of the need for privacy when dealing with mothers' personal health.

## 2 Choice of Methods

### *Contraceptives discussed*

Observers were asked to record contraceptive methods discussed during interactions between nurses and family planning clients. The average number of methods providers mentioned to new and revisit clients was two and one respectively. Compared to those revisiting, new clients were more likely to be told of different contraceptives. For oral contraceptives and the injectable, most providers talked about the method that the revisit clients were using. This suggests that discussions for revisit clients focused on management of contraceptive problems.

**Figure 7: Satisfaction with Services for FP and MCH Clients**



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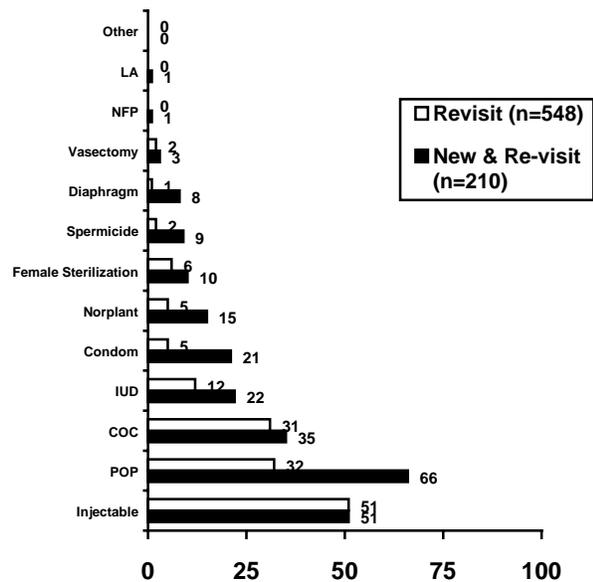
For example, See L Ndhlovu et al, "An Assessment of Clinic-based family planning services in Kenya", The Population Council, Nairobi, January 1997.

During counseling sessions, most new clients were told about progestin only pills while, for revisit clients, depo provera was most frequently mentioned to them (Figure 8). Long term and permanent methods which are generally less available at health facilities were less frequently discussed. For example, discussions that included vasectomy, tubal ligation, Norplant implants were very few.

The 1991 and 1996 ZSA studies collected some comparable data about contraceptive methods which were mentioned during interactions between providers and FP clients. The analysis showed an increase in the percent of women who were told about each of the contraceptives except condoms. The proportion of clients who received information about condoms decreased from 39 percent in 1991 to 21 percent during the 1996 ZSAS. A possible explanation for this remarkable decrease was provided by nurses during provincial dissemination workshops. They stated that nurses normally do not discuss condoms during interactions with clients but display condoms at convenient locations in the clinic to enable clients to pick them whenever they want to. However, a drop of nearly 20 percent between the two periods should be a source of concern for the family planning program as it seeks to promote condom use for pregnancy and STI prevention.

Oral contraceptives and the injectable continued to rank high in client provider discussions while permanent methods were lowest. In 1991, the injectable was discussed only in 2 percent of interactions and yet in 1996 it was the method most commonly mentioned among revisit clients.<sup>9</sup> Apart from depo provera, progestin only pills (POP) were found to be the most frequently discussed method with clients for both surveys. This could be a result of the large percent of women in Zimbabwe who initiate FP while they are breast-feeding. Almost 48 percent of clients who came for FP services reported that they were breast-feeding.

**Figure 8: Methods Mentioned to New and Revisit Family Planning Clients During Interactions with Providers (n=758)**



<sup>9</sup> The restriction of depo provera in the Zimbabwe family planning program was lifted in June 1992.

### *Provider restrictions on method provision*

A number of Situation Analysis studies have found that access to FP services is restricted partly because of unfavorable provider attitudes. This section explores the restrictions imposed by providers on their clients with respect to four client characteristics; age, number of children, marital status and spousal consent. Providers were asked if they set a minimum age for clients or they required them to have a minimum number of children before they could prescribe contraceptives. In addition, providers were asked if they would prescribe methods to unmarried women or those who did not have consent of their spouses to use contraceptives. These questions were asked with respect to oral contraceptives (POP and COC), condoms, IUDs, the injectable, implants and female sterilization. In a series of workshops held in 1995, new policy guidelines to remove medical barriers were disseminated in the country's provinces. Therefore, the second Situation Analysis Study provided an opportunity to evaluate the extent to which the guidelines had been implemented since 1995.

Most providers tended to restrict access to contraceptives on the basis of age (Table 7). Providers set different minimum age levels for oral contraceptives, condoms, IUDs, implants and female sterilization. The minimum age of 16 years was set for oral contraceptives and condoms, 18 years for IUDs, injectable and implants. The minimum age requirements for female and male sterilization rose steeply to 26 and 29 years respectively. Surprisingly, the largest percent of providers impose age restrictions for the most popular methods, COCs (76 percent), POPs (75 percent) and the injectable (66 percent) and less for IUD, sterilization and condoms. When depo provera was re-introduced in 1992, the MOH&CW stipulated that women needed to be at least 18 years and have a child as eligibility criteria. The 18-year minimum age restriction applies to all long term methods. Perhaps, the age restriction of 16 years cited for oral contraceptives and condoms is related to the Zimbabwe's Age of Consent (16 years), that is, when a minor can legally consent to have sexual relations. The providers' attitude on age requirements corroborate findings from other studies in the region about difficulties faced by adolescents and unmarried clients in accessing contraceptive services at standard health facilities.<sup>10</sup>

On this basis, clients' parity, marital status and requirement for spousal consent, a higher percent of providers impose these restrictions more for long term and permanent methods than for oral contraceptives and condoms (Table 7). For these three restrictions, the highest percent of providers restricted the provision of female sterilization. Requirements for marriage and for clients to have children show a wide variation. Apart from female sterilization, requirements for spousal consent are uniformly clustered around 20 percent for all the methods. This suggests that at least a fifth of providers would require clients to have a spouse before they can prescribe any FP methods. The policy guidelines disseminated during the medical barriers workshops in 1995 emphasized the clients' choice with extensive counseling for clients seeking permanent methods.

In light of the evidence presented above, it appears that a significant proportion of service providers in Zimbabwe continue to restrict clients' access to contraceptive services based on

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<sup>10</sup> Transgrud "Adolescent Sexual and Reproductive Health in Eastern and Southern Africa". (Draft). Prepared for USAID/REDSO, May 1997.

age, parity, spousal consent and marriage. To address these restrictions, a more concerted effort in disseminating the latest policy guidelines at regional and facility levels is recommended. The 1991 study did not collect data on medical barriers and a comparison with 1996 cannot be performed.

**Table 7: Percent of Providers by Type of Restrictions they Impose on Service Provision (n=348)**

Contraceptive method	% setting minimum age	% requiring children	% requiring marriage	% requiring spousal consent
COC	76	20	9	21
POP	75	19	10	21
Condom	44	4	5	23
IUD	57	27	19	24
Injectable	66	37	14	21
Implants	52	28	22	25
Female sterilization	60	55	34	55

To investigate prescription practices at health facilities, providers were presented with a number of hypothetical situations. Firstly, they were asked what methods they would recommend for women who wanted to space their next births and those who did not want to have any more children. Secondly, providers were asked what methods they would recommend for clients with STIs.

Table 8 shows that a high proportion of providers would make appropriate recommendations for spacing, terminating child bearing and for women with STIs. At least 58 percent of providers reported that they would recommend hormonal methods and the IUD for spacing purposes. Condoms, diaphragms and spermicides were recommended by a smaller proportion of providers and this may be a result of the perceived ineffectiveness of these methods and the general unavailability of diaphragm and spermicides at the facilities. Poor knowledge is demonstrated by the small percent of providers who reported that they would recommend permanent methods for spacing purposes. With regard to terminating child bearing, at least 87 percent of providers would recommend male and female sterilization.

By and large, providers demonstrated correct prescription practices for women with STIs. They showed awareness of risk factors associated with the use of the IUD for clients with STI infections.

There is a small percentage of providers who would give inaccurate information to clients wanting to space child birth or those with STIs. This situation can be rectified by supervisors discussing these issues during their visits to health facilities.

**Table 8: Percent of Providers Who Would Recommend Methods under Different Circumstances.**

Contraceptive method	Delaying or spacing	Terminate child bearing	Clients with STI
COC	74	5	92
POP	68	3	92
IUD	68	16	7
The injectable	86	23	93
Implants	58	19	97
Condoms	43	1	96
Diaphragm	20	1	84
Spermicide	16	3	92
Female sterilization	5	94	95
Vasectomy	3	87	96
NFP*	10	1	98
LAM**	7	0	98

\* = Natural family planning

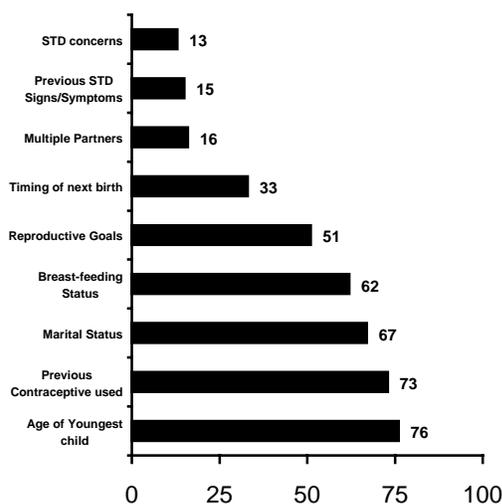
\*\* = Lactational amenorrhoea

### 3 Information Exchange between Providers and Clients

#### *Assessing client's needs*

A satisfactory prescription of contraceptives depends largely on the providers' assessment of women's circumstances and needs through observations and a series of questions. These questions take account of the clients' reproductive goals, sexual relations, concerns about STIs and contraceptive experience. Figure 9 shows that there was a wide variation in the way providers assessed the clients circumstances. During interactions with new/restart FP clients, the largest proportion of providers assessed the age of the youngest child, previous contraceptive experience and the woman's marital status. Questions to assess clients for STIs (previous/current signs of STI, STD concerns and number of sexual partners) were least asked.

**Figure 9: Information Used to Assess Client's Reproductive Health Needs (n=210)**



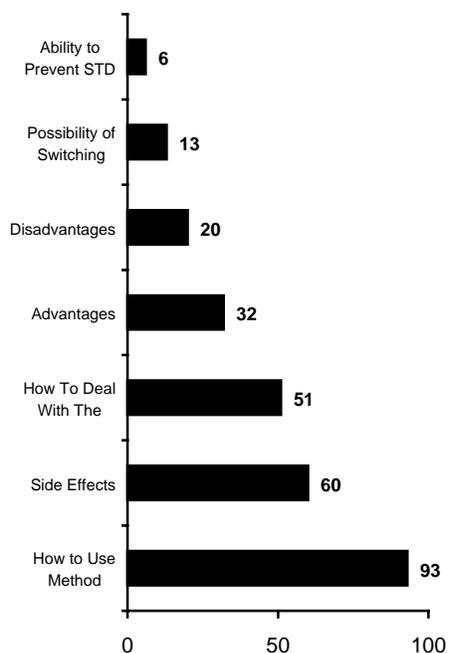
A comparison of interactions with new and revisit clients shows that, for every factor assessed, a higher proportion of providers assessed new clients about their reproductive situation compared to those revisiting. This is expected since revisit clients are likely to have benefited from earlier contacts with service providers.

The two ZSA studies permit for comparison of only two assessment factors (reproductive goals and breast-feeding status) for new clients. For these two factors, the percent of providers soliciting information about reproductive goals and breast-feeding status has decreased. In the 1991 ZSAS, 64 percent of women were asked about their reproductive goals while 83 percent were asked about their breast-feeding status. For the same factors, the figures decreased to 51 and 65 percent respectively in 1996. Though the data restricted the comparison to only two factors, this decrease may be an indication of decreasing quality of services offered to women.

*Information on methods chosen*

When providers prescribe a method, the expected practice is that they should provide information to the client about how to use it, its side effects and their management, advantages and disadvantages of the method and the possibility of switching to other methods (Figure 10). For 168 new clients whose interaction resulted in a prescription of a method, observers recorded data on information given about the chosen contraceptive method. Data displayed in Figure 10 show that over 93 percent of providers told their clients how to use the method; 60 percent talked about possible side effects and just over half discussed how clients should manage the side effects. Less than a third of women were told about advantages and disadvantages of the methods. The possibility to switch methods in case the client found the contraceptive disagreeable or that some methods prevent STIs was discussed in less than 15 percent of provider client interactions.

**Figure 10: Information on Method Given to New Clients (n=168)**



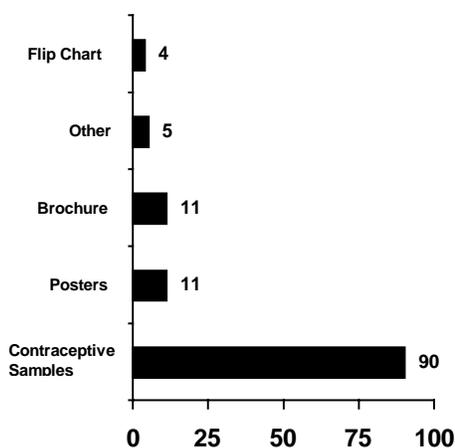
The 1991 and 1996 studies collected three common data items on the information given about contraceptives; how to use the method, its side effects and management. Comparison of data on these issues show that there was an insignificant increase in the percent of providers discussing how clients should use the method given. On the other hand, smaller percentages of women were told about side effects and their management in 1996 than in 1991. For the two study periods, the percent of women told about side effects and their management decreased by 12

and 24 percent respectively. Considering the extensive literature about method discontinuation caused by side effects, this is an area that needs program attention and reinforcement.

*Use of IEC materials during Provider - Client interactions*

**Figure 11: Use of IEC Materials During Provider - Client Interaction**

During counseling sessions, the use of IEC materials,<sup>11</sup> other than contraceptive samples, was observed to be low for both new and revisit clients. Ninety percent of providers used contraceptive samples as an aid for counseling clients. Posters and brochures were used in just over 10 percent of provider - client interactions. Flip charts, which are designed for counseling purposes, were rarely used even at health facilities where they were available (Figure 11). These results suggest that ZNFPC should increase the supply of counseling materials to facilities and providers should be trained in their use.



**4 Technical Competence During Clinical Procedures**

Policy guidelines require service providers to do medical examinations with new and restart family planning clients when they seek services at facilities. Medical examinations are recommended every two years for revisit clients or when STIs are suspected or if the client requests for it. Table 9 shows that providers follow these guidelines since they tend to conduct medical examinations with a higher percent of new clients compared to those revisiting.

For the majority of new and revisit clients, blood pressure and weight were taken by health providers. In addition, a large percent of these women were asked about their last menstrual period (Table 9). Taking medical history was twice as likely to be conducted among new clients compared to those revisiting.

<sup>11</sup> See Table 6 for IEC materials which were available during the data collection period.

**Table 9: Technical Competence of Providers by Clinical Procedures Conducted for New and Revisit Clients**

Procedure undertaken	% of new clients	% of revisit clients
Take blood pressure	91	94
Last Menstrual Period (LMP)	88	83
Take weight	87	92
Medical history	62	34
Breast examination	44	9
General physical examination	41	11
Vaginal examination	33	11
Vaginal bleeding	29	22
Vaginal discharge	23	8
Abdominal pain	22	12
Pap smear	9	3
Syndromic analysis	7	3
Genital itching	5	4

Procedures for assessing cancer and STI risk factors for women were found to be infrequently carried out. Breast examinations require no equipment and yet these procedures were conducted in only 44 percent of new and 9 percent of revisit clients. Considering the importance of this procedure for early detection of breast cancer, it should be encouraged. Evaluation for cervical cancer through pap smears was observed in less than a tenth of women. Less than 10 percent of providers used the syndromic approach to screen clients for sexually transmitted infections. Procedures for determining the possibility of STI infection were also not commonly performed. For example, questions about genital itching, vaginal discharge and abdominal pain were asked in less than a quarter of new FP clients. The figures are even lower for revisit clients.

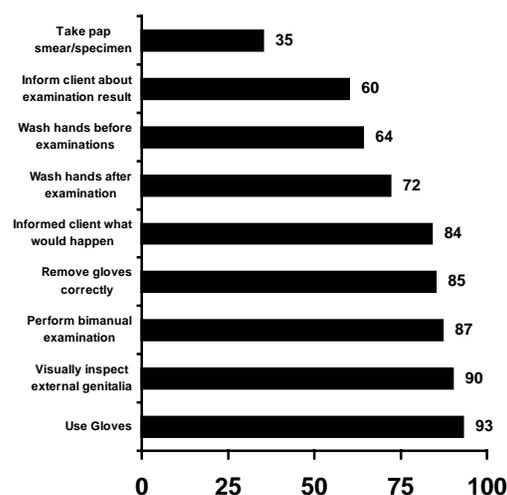
An analysis of clinical actions taken in 1991 and 1996 to assess providers' technical competence reveals an inconsistent pattern. Data were compared to examine changes in the percentages of new and restart clients who had medical history, weight, blood pressure and pelvic examination performed. The percent of providers taking weight measurements increased by five percent while those taking blood pressure has remained constant at 91 percent. Medical and pelvic examination have decreased by 9 and 24 percent respectively. In 1996 gynecological history was measured through specific questions on vaginal discharge and bleeding while in 1991, the questions were less explicitly stated. However, indications are that assessment of gynecological conditions have declined by at least 55 percent. Since the campaign against medical barriers in 1995, vaginal examinations and pap smears are no longer routine requirements for revisit clients. However, considering the low percent of new and revisit clients who have a syndromic assessment for STIs, some measures need to be put in place so that women can have some form of STI diagnosis and management.

## Pelvic examinations and other procedures

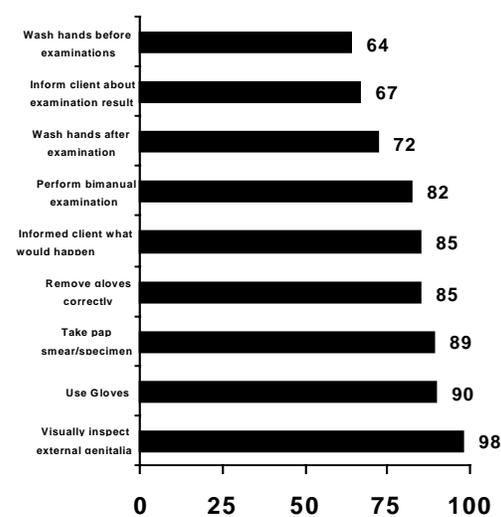
Data collectors observed 134 pelvic and 124 speculum examinations. Procedures that were conducted for the examinations are indicated in Figures 12 and 13. Overall, results suggest that providers follow proper procedures during pelvic and speculum examinations but there is ample room for improvement. For over 85 percent of the examinations, providers informed clients about what to expect and yet a far smaller percentage told them about the results of the examination. There is need for providers to improve on the information they give to clients after these examinations.

While a majority of providers used gloves during the pelvic and speculum examination procedures, there were seven percent and 10 percent of providers respectively who were observed to have performed these examinations without gloves (Figure 12 and 13). This should be greatly discouraged in view of the need to prevent cross infections between the providers and the clients. At least a third of providers did not wash hands before or after the pelvic examination. The washing of hands prior to the examinations is less worrying since a majority of providers used gloves for both examinations. Providers who were found deficient in these skills are spread across all the sectors. This group of providers needs some assistance so that they may improve their skills.

**Figure 12: Procedures Performed During Pelvic Examination**



**Figure 13: Procedures Performed During Speculum Examination**



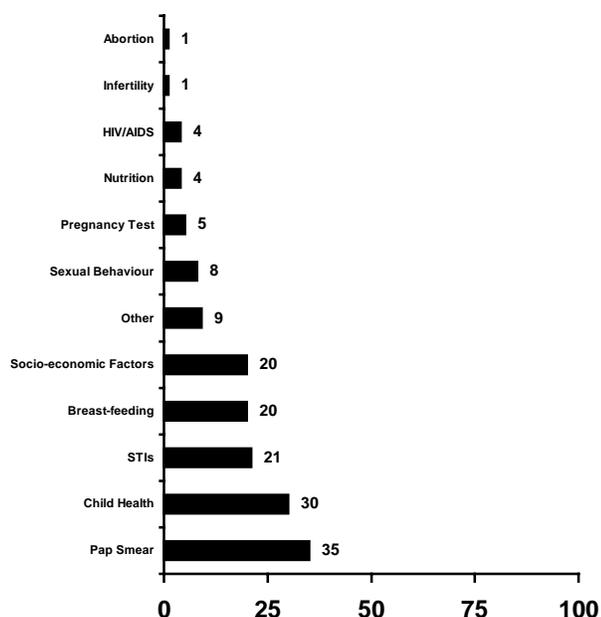
## 5 Mechanisms to Encourage Continuity

The majority of clients (77 percent) were told when to return for contraceptive resupply. For nearly two thirds of this group, the resupply information was confirmed by giving women written reminders. More than three quarters of clients were told where to go for resupply. Close to 90 percent of clients were told to return to the same facility, while about 17 percent were referred to another facility. Referrals to CBDs or Depot Holders and other facilities were made in 6 and 4 percent of cases respectively.

## 6 Integration of FP with Other Health Services

Integration of MCH and STI services with FP is part of the strategic plan of the MOH&CW and the ZNFPC. Observations of provider client interactions showed that providers discuss issues other than FP to varying degrees. It was observed that 54 percent and 38 percent of new/restart and revisit FP clients respectively had some discussions about other issues besides family planning with service providers. Figure 14 shows that the three most dominant topics discussed during interactions were pap smears, child health and breast feeding. Priority given to these topics were found to be the same for both new and revisit clients. Interviews from MCH and FP clients confirm that providers talk to them mostly about child immunization and growth. Both observations and interviews confirm that few discussions include STIs. This should be a worrying concern especially considering the extent of the STI/HIV/AIDS problem in Zimbabwe.

**Figure 14: Other Issues that Were Observed to be Discussed with New and Revisit FP Clients (Percent)**



### ***D PROVISION OF STI SERVICES***

In response to the impact of HIV/AIDS on curative services and the relationship between STI and HIV/AIDS, the MOH&CW set up the STI programme in 1994 which, among other things, aims to strengthen provider skills in the diagnosis and management of STIs at health facilities. In the past five years, service providers in the public sector have undergone training in STI-related topics, and the Government of Zimbabwe procures STI drugs mainly through the STI programme. This section examines the availability of STI services, their management at health facilities, in addition, clients' knowledge of signs and symptoms is explored. No comparison is made between the 1991 and 1996 Situation Analysis Studies since the inquiry in the earlier study did not include questions on sexually transmitted infections.

## 1 Availability of STI/HIV/AIDS Services

Facility managers were asked to indicate what STI and HIV/AIDS services were provided at their health facilities. In nearly all health facilities, managers reported that their health facilities provided counseling and treatment services for sexually transmitted infections. The diagnosis of sexually transmitted infections was based on the syndromic approach (94 percent of facilities) with the laboratory assessments conducted in just over a tenth of facilities. As expected, HIV/AIDS testing was done at a small percent of facilities though nearly two thirds of facilities were reported to provide HIV/AIDS counseling services.

Limited laboratory facilities at most health facilities leave service providers with few options of diagnosing STI infections except to rely on the syndromic approach. When clinic managers were asked what STI tests were available at their clinics, responses show that the most common test was for syphilis (Figure 15). Tests for gonorrhea, chlamydia, candida and HIV were each reported to be available in less than a tenth of facilities.

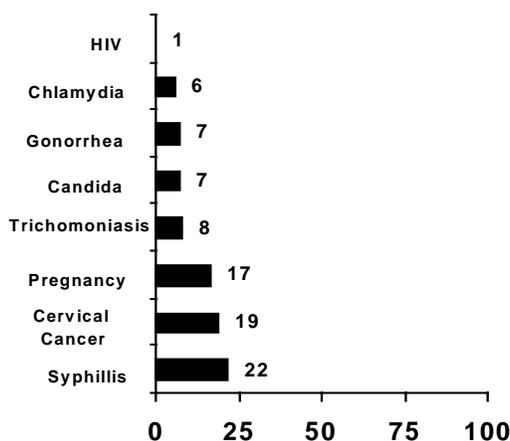
Despite the limited availability of testing services, referrals to other service facilities with laboratory services were relatively low. The highest percentage of facilities referred

clients for syphilis, pap smear and HIV testing, respectively 61, 57 and 52 percent. Providers may feel they are able to diagnose some of the sexually transmitted diseases using the syndromic approach and therefore do not need to refer clients. In some cases, referral facilities may be too far for clients to access and providers could view it as futile to refer clients. These findings support the call by the ZNFPC to examine providers' diagnosis skills and clients' understanding of sexually transmitted diseases. Additionally, in view of the extensive reliance of the syndromic approach, the reliability on this method needs to be assessed against laboratory based testing. The ZNFPC has already embarked on some projects to address these issues.

## 2 Provider Training and Skills in Providing STI Services

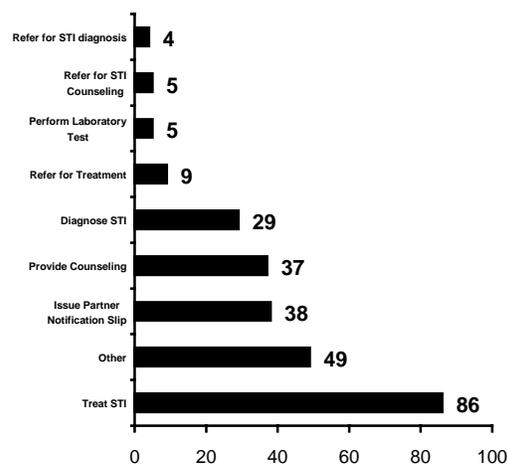
Over 80 percent of service providers who stated that they normally provide counseling, diagnosis and treatment of sexually transmitted infections were found to be distributed in 86 percent of health facilities. The 26 facilities where there were no providers who had any of these skills were mostly found in rural health centers that belong to rural district councils.

**Figure 15: Availability of Screening Tests for STIs at Health Facilities (n=192)**



Fifty-eight percent of providers reported that they had attended refresher or post basic courses that included training in counseling and management of AIDS and sexually transmitted infections. These providers had attended a number of courses on STI risk assessment (75 percent), the syndromic approach (66 percent), STI counseling (72 percent) and HIV counseling (59 percent). For almost all the courses, the providers had attended them within the last three years. This indicates the effort undertaken by the Government and Non Governmental Organizations in training service providers in STI/HIV management and prevention.

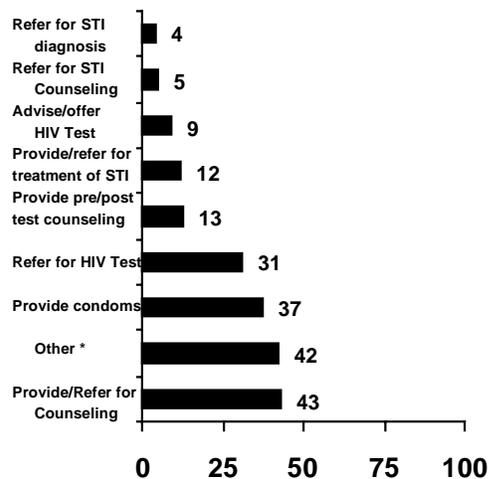
**Figure 16. How Providers Would Manage Clients Suspected of Having STIs (n=348)**



Note: Other = Provide Condoms

To assess services that providers deliver to STI and AIDS patients, providers were presented with two hypothetical situations; firstly, what they would do if they suspected that a client had an STI and secondly, that a client had HIV/AIDS. The low percentage of responses and their spread across different actions in Figures 16 and 17 suggests a lack of clear policy guidelines for providers to follow. From Figure 16, it is commendable that most providers stated that they would treat the clients for the STI infections. However, the low levels of referrals for STI diagnosis, counseling and laboratory testing are rather worrying. The second largest percent of providers stated that they would provide condoms or examine the clients. Provider responses to clients suspected of having HIV/AIDS infection are shown in Figure 17.

**Figure 17. How Providers Would Manage Clients Suspected of Having HIV/AIDS (n=348)**



Note: Other = Manage signs and symptoms of opportunistic infections

Though the pattern is similar to the one observed for STI clients, the largest proportion of providers said that they would refer or provide counseling services followed by providers who stated that they would manage signs and symptoms of opportunistic infections.

### 3 Availability of Drug and Supplies for STI Treatment

Table 10 shows that most health facilities have a reasonable range of supply of first and second line commonly used drugs for the treatment of STIs. For clients with contraindications to first line drugs due to pregnancy, allergy or sensitivity, substitute drugs were available.

Considering that some drugs can be substituted for treatment, the implications of the stock out situation cannot be assessed accurately. However, the relatively high percentage of facilities reporting stock-outs should call for concern and a more accurate assessment. It is recommended that each clinic should have at least one drug in each category, that is, first or second line treatment and substitutes for contraindicated clients.

**Table 10 Availability of STI drugs on the Day of the Visit and Reported Stockouts Six Months Preceding the Study (n=192)**

STI Drugs	% of facilities with STI drugs	% of facilities reporting stock-outs
Kanamycin	64	60
Norfloxacin	5	25
Cotrimoxazole	92	24
Tetracycline	5	27
Benzathine penicillin	67	50
Doxycycline	87	32
Metronidazole	85	29
Erythromycin	25	33
Procaine penicillin	88	18

### 4 Clients' Knowledge of Signs and Symptoms of STI

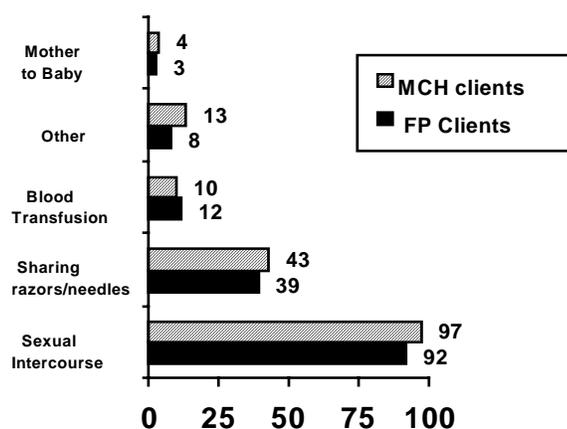
The ability of clients to identify signs and symptoms for sexually transmitted infections is an important step towards seeking proper medical care. Based on exit interviews with both MCH and family planning clients, the study found that nearly all clients knew that there are diseases that are transmitted through sexual intercourse. Asked about what the common signs and symptoms for these diseases were, the majority of clients named lesions or sores as common signs (Table 11). The second most commonly known symptoms were the presence of lower abdominal pain and abnormal vaginal discharge. The rest of the signs and symptoms (abnormal vaginal bleeding, genital itching or warts, urethral discharge, painful urination, painful intercourse) were mentioned by less than a fifth of either MCH or family planning clients.

**Table 11 Percentage of MCH and FP Clients Who Spontaneously Mentioned Signs and Symptoms of STIs**

Reported signs/symptoms of STIs	% of FP clients (n = 723)	% of MCH clients (n = 917)
Abnormal vaginal discharge	26	31
Abnormal vaginal bleeding	4	6
Genital itching	17	23
Lesions / sores	53	67
Lower abdominal pain	28	36
Pain during intercourse	4	6
Painful urination	14	15
Genital warts	4	3
Urethral discharge	4	6
Loss of weight	7	16
Chronic diarrhoea	6	8
Other symptoms	11	22

Though almost all the women had heard about AIDS, knowledge of the transmission of the disease is virtually confined to sexual intercourse. Sharing razors and needles ranked as the second most commonly mentioned mode of transmitting the AIDS virus. Transmission through blood transfusion was mentioned by approximately a tenth of the MCH and FP women (Figure 18). Less than five percent of each group of women mentioned vertical transmission from mother to baby.

**Figure 18: MCH and FP Clients Reporting Different Modes of HIV/AIDS Transmission**



Women’s knowledge about HIV transmission probably captures the main message passed by various programs operating in the country; that the HIV virus is transmitted through sexual intercourse. It is important that programs should also emphasize the other modes of transmission. For example, couples with one or both partners infected need to make informed decisions about having children in light of the evidence about vertical transmission of the virus.

Given the above discussion, there is scope for the program to introduce interventions for clients and providers. The largest proportion of clients demonstrated knowledge of only three signs or symptoms of sexually transmitted infections and even in this group, knowledge levels were found to be relatively low. Public education campaigns at facilities and communities are suggested to improve the clients’ level of knowledge. Provider responses to questions on the

management of AIDS and STD patients show low levels of referrals for counseling or diagnosis. Facilities without adequate diagnosis, treatment and counseling services need to establish better referral systems to other health facilities.

Through refresher training, nearly 60 percent of providers were equipped with different skills in identifying and managing sexually transmitted infections. However, observations show that providers are not applying these skills when they interact with clients. It is clear that training is not sufficient to ensure that providers use their skills. There is need for a more focused evaluation of applicable ways of ensuring that trained providers use these skills to benefit the community.

## **IV KEY FINDINGS OF THE CBD PROGRAMME**

The Community Based Distribution (CBD) program is the principal outreach mechanism for family planning services to the rural communities of Zimbabwe. Once the ZNFPC identifies an area requiring community workers, the community selects suitable candidates to operate in the area. Important attributes for the community workers are maturity, good health, reliability, attainment of secondary school education and a positive attitude towards contraceptive services.

The training of CBDs and the supervision provided through the ZNFPC and the Ministry of Health and Child Welfare structure ensures their effectiveness. Once the CBD cadres complete their training, they become fully salaried employees of the ZNFPC, and their duties include educating, counseling and initiating women to contraceptive use. In addition, they refer clients to health facilities for problem management, long term and permanent methods. During their field activities, each group of 8 to 12 CBDs is supervised by a group leader who visits them one to three times in a period of three months. Over the years, the program has grown such that by the end of 1997, there were over 800 Community Based Distributors providing services in the rural areas, commercial farms, and peri-urban areas. This extensive network of health workers may explain the 1994 Zimbabwe Demographic Health Survey finding that 18 percent of women who were current users of modern FP methods were receiving their contraceptive supplies from CBDs.

Over the years program managers have expressed concern that the CBD program is expensive and not sustainable and that alternative approaches needed to be developed. Based on this, the first Zimbabwe Situation Analysis Study (1991) included questions that sought to find out the feasibility of using alternative systems where contraceptive users could obtain their supplies from a fixed point (depot holder) while the community based distributors concentrated their efforts on recruiting new clients. The results from the study showed that clients were willing to obtain their supplies from a depot-holder instead of a CBD. Since the first Situation Analysis Study, the depot holder model has been piloted in two districts and there are plans to expand the model to all eight provinces of the country.

The sampling scheme for group leaders and CBDs for the 1991 and 1996 Situation Analysis Studies are similar and comparisons can be made for a number of variables. During the 1996 ZSAS, there were 641 CBD-client interactions observed, 635 CBD client exit interviews, 144 CBDs and 19 group leaders interviewed. Of the 641 client interactions observed, 61 percent were for resupply providers, 17 percent were new/restart clients, 17 percent were clients experiencing problems with their current method, 3 percent wanted to switch methods and 2 percent had other reasons for meeting health workers. In the 1991 survey, 146 observations of CBD client interactions were made. Of this group, 59 percent were continuing users, 25 percent were new or restart clients, 14 percent were consulting for problems and the rest came for other reasons.

The following sections examine contraceptives, equipment, record books and IEC materials that CBD agents carry. Further, service quality provided to clients is discussed based on observations of interactions between the CBD agents and their clients. The training and supervision of CBDs as part of their preparedness to deliver quality services is also discussed.

## **A LEVEL OF CBD ACTIVITIES**

The median number of clients served by a CBD for three months (May to July 1996) is 21 new visits, 580 revisits and 13 referrals. The mean number of hours per day spent by CBDs resupplying continuing clients is 5 hours which is equal to the mean reported in the 1991 study. These results clearly show that CBDs continue to spend most of their time resupplying old clients rather than recruiting new clients. The recommendation that the CBD program should be redirected so that these agents shift their emphasis from resupplying clients to recruiting new ones and referring them for long term and permanent methods is reiterated. The introduction of depot holders in some CBD catchment areas is a positive step in this direction and the ZNFPC anticipates an expansion of the project after a careful review of the pilot studies.

## **B FUNCTIONING OF CBD SUBSYSTEMS**

### **1 Contraceptive Stocks in CBD Shoulder Bags**

Table 12 shows the quantities of contraceptives observed in the CBD shoulder bags during the day of the study. The quantity of contraceptive supplies that are carried by CBDs depends on the number of clients that a CBD intends to visit for the day. A majority of CBDs were carrying at least 10 cycles of Lo-femenal and Ovrette and 10 pieces of condoms. The median number of cycles of Lo-femenal (COC), Ovrette (POP) and condom pieces carried by CBDs was 30, 26 and 60 respectively. Compared with 1991, these figures are a marked improvement in the quantity of contraceptives carried by CBDs in their bags. For example, in 1991, 17 percent of the CBDs did not have any condoms in their shoulder bags while in 1996, only one CBD was not carrying condoms.

**Table 12: Percent of CBDs with Contraceptives in their Shoulder Bags**

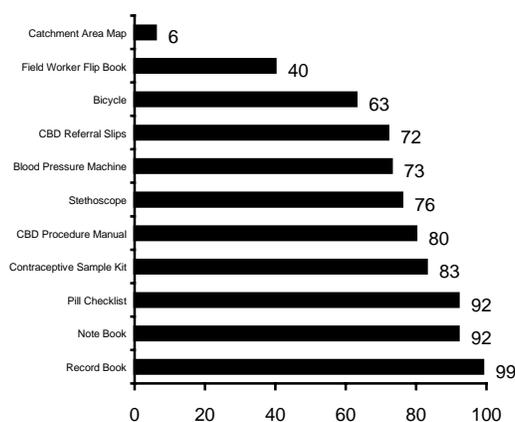
<b>NUMBER OF CYCLES/PIECES</b>	<b>COC</b>	<b>POP</b>	<b>CONDOMS</b>
0	0	1	1
1 - 9	8	7	5
10 - 24	31	41	13
25+	61	51	81
Number of CBDs <sup>12</sup>	140	143	125

<sup>12</sup> The variation on the number of CBDs carrying each method is due to the missing data for the respective variable.

## 2 Equipment

Figure 19 shows that a high proportion of CBDs were carrying most of the equipment that they are expected to have during client visits. A comparison of the 1991 and 1996 studies showed that there was an increase of at least 30 percent of CBDs who had blood pressure machines or stethoscopes in their shoulder bags. The improved availability of equipment is expected since the ZNFPC provided CBDs with new equipment after the 1991 ZSAS.

**Figure 19: Percent of CBDs Carrying Particular Equipment During Client Visits (n=144)**



## 3 IEC Materials

Though CBDs rely heavily on IEC materials for their work, they were found with only a limited variety of information sheets. The 1996 study found that the majority of CBDs had POP (77 percent) and COC (75) instruction sheets while only 47 percent were carrying the condom instruction sheets. The low percentage of CBDs with condom instruction sheets is consistent with findings elsewhere which show that low attention is paid to this method. If the CBDs are to fulfill their role as information agents, they will need greater support in terms of updated information and training in the use of IEC materials. Considering the high interaction of CBDs with their communities, the ZNFPC should explore the possibility of using them to distribute other materials to these communities.

The 1996 study also noted increases of CBDs who carried contraceptive sample kits and referral slips; respectively 22 and 42 percent. Though CBDs are required to carry procedure manuals during field visits, over a fifth of them did not have them both in the 1991 and 1996 studies. On a number of occasions CBDs have explained that they find Procedure Manuals too heavy to carry on a daily basis. In addition, CBDs have called for the ZNFPC to provide them with better quality IEC materials since they have found the durability of some of these materials limited. For example, checklists would be better preserved if they were laminated.

## 4 Supervision

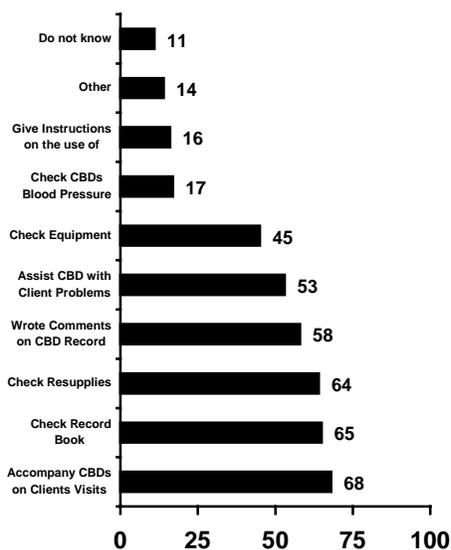
The basic structure for supervising CBDs is through group leaders who use motor bikes to visit a number of CBDs and resupply them with contraceptives. The ZNFPC has allocated each group leader an allowance of 700 kilometres per month for these visits. Though group leaders have complained that this mileage is insufficient, the ZSAS found that all CBDs were supervised at least once during the three months preceding the study. Contrary to expressed fears by the group leaders that they would be forced to reduce the number of their visits, the median number of supervisory visits increased from two to three visits between 1991 and 1996. Also, most CBDs (86 percent) were of the opinion that supervisory visits by group leaders were adequate.

By and large, group leaders performed most of the activities expected of them during supervisory visits (Figure 20). The inability to perform all the activities can be avoided if all the group leaders adopt the habit of using the supervisory checklist routinely.

## 5 CBD Training and Experience

Community based workers are well trained and experienced with providing family planning services. Nearly all (95 percent) of them had attended refresher courses since their basic training. The majority of them (79 percent) had attended these courses within a year of the data collection exercise. The rest had their refresher training two or more years since the date of interview. The median number of years of post-basic training experience for CBDs was 12 years with a majority (77 percent) of CBDs having more than 5 years of experience. The proportion of CBDs who reported that their basic training course was inadequate for them to fully carry out their duties increased from 29 percent in 1991 to 42 percent in 1996. Although this study did not investigate the content areas of the CBD basic course, this finding suggests the need to investigate what some of the CBDs feel are the weak aspects of their training. The fact that CBDs are increasingly called upon by their communities to perform duties beyond providing family planning services may account for the inadequacy reported. For instance, community members seek for advice from CBD agents on a wide range of topics on MCH and reproductive health issues.

**Figure 20: Activities Performed by Group Leaders During Supervisory Visits (n=124)**



## 6 Record Keeping

Good record keeping systems are an essential part of the CBD activities since these records are compiled to monitor and evaluate the output and effectiveness of the CBD agents. Though fifty-nine percent of CBDs had their record books in a satisfactory condition, a significant number of them were found with torn pages. The deterioration of record books is clearly brought out by a comparison of the two surveys. In 1991, 94 percent of CBDs had their record books judged as clean, readable and without any torn pages and yet in 1996 only four percent were judged the same. This state of record books is puzzling since new books were distributed to all CBDs in 1995. A possible explanation is that the quality of record books purchased then may have been of low quality. Despite this state of record books, interviewers observed that a majority (93 percent) of them had detailed client's addresses that could allow for easy follow-up. Nearly 97 percent of record books had group leaders' comments written for the three months of May to July 1996.

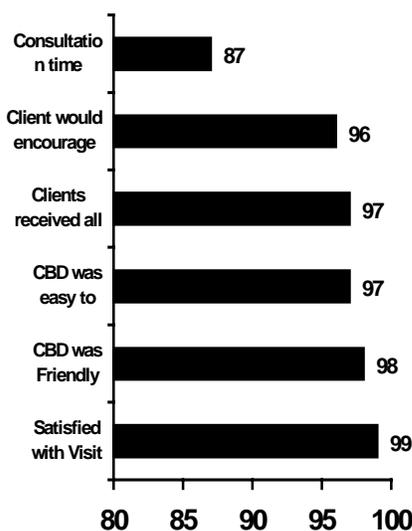
## C QUALITY OF CARE FOR THE CBD PROGRAMME

The assessment of service quality for the CBD programme was based on CBD-client interactions, interviews with CBDs and clients. As is the case with static health facilities, the quality of care indicators are based on the Bruce-Jain framework of quality of care.

### 1 Interpersonal Relations

Like their counterparts at health facilities, CBD clients expressed high levels of satisfaction during their interaction with service providers. Clients were asked several questions about their level of satisfaction with services received. They reported that CBDs were friendly and easy to understand. Nearly all clients reported that they received all the services they sought and felt that the duration of their consultation time was acceptable (Figure 21).

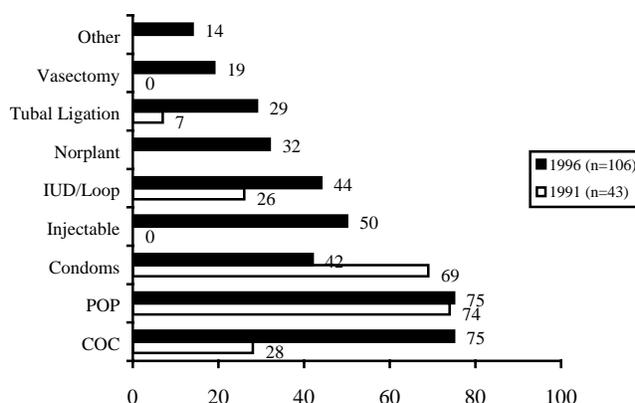
Figure 21: Clients' Satisfaction with Services Offered by CBDs (n=635)



## 2 Choice of Methods

Method choice can be affected by clients' knowledge of methods, method availability, CBD biases and attitudes. The ZNFPC programme allows CBDs to provide only two methods; pills and condoms. In the 1996 survey, almost all the CBDs interviewed were carrying these two methods during their client visits (Figure 22). While most new or restart clients were told by CBDs about combined oral and progestin only pills, less than half of them were told about condoms. A fairly large proportion of new/restart clients were also told about the injectable (50 percent) and the IUD (44 percent).

**Figure 22: Methods Mentioned by CBDs During Interaction With New/Restart Clients**



The 1996 survey showed an improvement over 1991 in the proportion of CBDs who told their clients about other methods besides condoms and pills. The proportions of new/restart clients who were told about COCs, IUDs and tubal ligation in 1990 increased significantly compared to 1991. CBDs never mentioned depo provera, Norplant implants and vasectomy during their interactions with clients in the 1991 study and yet significant improvement is noted in the 1996 survey.<sup>13</sup> It is a worrying observation that the percent of CBDs who mentioned condoms to their clients decreased from 69 percent in 1991 to 42 percent in 1996. Considering that the condom is the only other method that CBD agents distribute and the concern of the high prevalence of STI/HIV/AIDS in the country, expectations would have been that CBDs discuss this method with a larger proportion of clients. Most CBDs used the contraceptive checklists during interactions with clients, but there is need to strengthen their counseling skills in general and specifically for condoms. They also need more general information about long term and permanent methods for which clients are referred.

Although discussion of other methods was limited to less than a third of interactions with new/restart clients, this shows an attempt by some CBDs to discuss a broad range of methods beyond what they are actually skilled to provide. CBDs are only equipped with the minimum basic information on the methods they do not offer to enable them to refer clients to clinics. Hence, a majority (81 percent) of CBDs reported that they would refer clients to other service providers for methods other than pills and condoms.

<sup>13</sup> *The provision of depo provera was restricted to very few cases between 1981 and June 1992 in Zimbabwe, hence, service providers were not permitted to promote the method during this period.*

### 3 Information Exchange

#### *Assessment of clients' needs*

CBDs do not solicit sufficient information from clients to allow them to assess their needs and take appropriate action. For example, only 38 percent of new/restart clients and 32 percent of revisit clients were asked about their reproductive goals. With respect to breast-feeding, in only 44 percent of interactions were clients asked whether they were breastfeeding or not. For CBDs to prescribe the correct oral contraceptive, they have to determine the breastfeeding status of women they serve. While it can be argued that CBDs know their clients well, in view of the large catchment areas that they serve, it is unlikely that they would remember the breastfeeding status of more than half of their new clients.

It is commendable that most CBDs (62 percent) inquired whether revisit clients were experiencing problems with their current methods. This figure is an increase of 12 percent over that recorded in the 1991 survey. However, it is a contradiction that only 41 percent of CBDs asked whether clients wanted to switch methods, showing that they are not offering sufficient possible solutions even in circumstances where there could be problems with method use. If CBDs could use the clients' checklist, this would ensure that they ask all relevant questions that would enable them to assess clients' needs adequately.

#### *Method-specific information given to clients*

Table 13 shows the information given to new/restart clients on Lo-femenal, Ovrette and condoms. During consultation with CBDs, the largest proportion of clients were told about how the pill works and how to use it. Other information about the pill effectiveness, side effects and their management, advantages and disadvantages was less frequently mentioned to clients. Specifically, about 62 percent of clients were not informed about possible side effects related to the use of oral contraceptives. The inability of the CBDs to give clients adequate information is a potential source of method discontinuation. While a larger proportion of new/restart clients received information on Lo-femenal and Ovrette (about 55 percent), a far smaller percent of them were told about condoms (22 percent) and how to use them. A similar pattern of findings was obtained from the 1991 study where side effects related to Ovrette were discussed with only 30 percent of new/restart clients compared to 38 percent in 1996, while condom discussions took place with very few clients.

**Table 13: Information Given to 106 New/Restart Clients on the three Methods Provided by CBDs**

Information Provided	Lo-femenal (COC)	Ovrette (POP)	Condoms
How method works	48	50	25
How to use method	53	55	20
Method effectiveness	28	29	10
Advantages and disadvantages of method	30	31	9
Possible side effects related to method	37	39	6
Management of method related side effects	39	40	7
Where method can be obtained	40	41	9

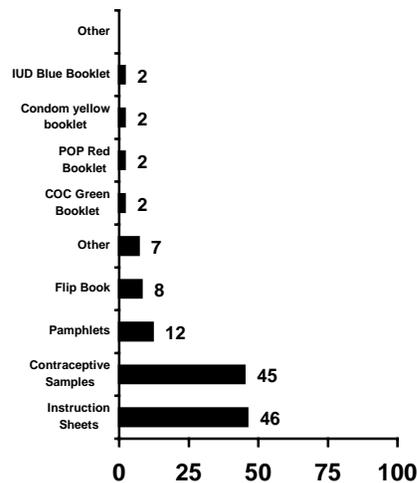
#### *Use of IEC materials*

The use of IEC materials depends on their availability and whether providers are skilled to use them. Figure 23 shows IEC materials used during interaction with new/restart clients. In view of the high percentage of CBDs carrying IEC educational materials, it is surprising that a small percentage use the IEC materials during counseling. The under-utilisation of IEC materials may be a result of lack of confidence in their use since CBDs are not trained in that regard.

Although 83 percent of CBDs were observed to be carrying contraceptive sample kits in their shoulder bags, only 46 percent used these as supportive materials during interactions with new/restart clients. There is need to review IEC materials regularly in terms of content, attractiveness and language, and then to train CBDs on their use.

CBDs have expressed an opinion that the materials that they carry are not appealing to clients and have been in circulation for many years.

**Figure 23: Percent of Interactions with New/Restart FP Clients Where Particular IEC Support Materials were used (n=108)**



#### 4 Technical Competence

The technical knowledge of CBDs was assessed on the basis of their Procedure Manual. Three hypothetical situations were presented to CBDs and they were required to indicate what actions they would take for each of them. The three situations presented were: 1) a woman requesting for the pill for the first time 2) a breast feeding woman requesting for the pill and 3) a revisit client. A summary of CBD responses is described below.

**a) Actions that would be taken by CBDs when interacting with women requesting for the pill for the first time:-** CBDs mentioned several actions they would take for such clients. The majority (97 percent) of CBDs said they would use the checklist, 76 percent would take the clients' blood pressure and 57 percent would tell the client about all the methods which are available in the program. Although the proportion of CBDs who would inquire about the client's reproductive goals in particular was low (14 percent), if they used the checklist, then they would ask about women's reproductive goals. Client provider interactions showed that most CBDs used checklists with clients.

**b) Actions that would be taken by CBDs when interacting with breast feeding women requesting for the pill:-** Fifty-four percent of CBDs mentioned that they would ask a breast feeding client about the age of the child. Thirty-one percent of CBDs said they would give clients POP if the age of the child was less than 12 months while 25 percent would give clients COC if the age of child was more than 12 months. The rest of the CBDs gave vague responses which may be a result of misunderstanding the question since a significant proportion of CBD clients were breast feeding (32 percent and 9 percent of new/restart and revisit clients respectively). The proportion of CBDs who stated that they would ask for the age of the child

increased from 39 percent to 54 percent between 1991 and 1996. Despite this increase, the wide variation in responses shows that a sizable percent of CBDs are not clear what the important issues are when dealing with breast feeding women.

*c) Actions that would be taken by CBDs with revisit clients:-* Seventy-four percent of CBDs said they would ask a revisit client if she has any method-related problems, 67 percent would take the client's blood pressure and 28 percent would use the checklist during interactions with revisit clients.

Although there is evidence of some improvement in the technical competence of CBDs since 1991, some of their actions are inconsistent and indicate lack of clarity about procedures to be followed; for example when dealing with breastfeeding women.

## 5 Mechanism to Encourage Continuity

Most of the CBDs informed their clients where and when they were to go to receive their next supply of contraceptives. Data collectors noted that 57 percent of clients' record cards showed the date of the next visit by the CBD. Further, 74 percent of new/restart clients and 51 percent of revisit clients were informed by CBDs of the date of the next visit.

## 6 Integration of Services

The degree to which CBDs can integrate services is limited by their level of training. Other than FP service provision, CBDs were found to give information on a number of different health issues. During their interactions with clients, the most frequently discussed topics were child health (61 percent), women's health (70 percent), breast feeding (23 percent) and STI/HIV/AIDS (30 percent).

**Table 14: CBDs and Clients' Knowledge of Signs and Symptoms of STIs**

Signs and Symptoms	Percent CBDs (n=136)	Percent Clients (n=430)
Abnormal vaginal discharge	79	44
Abnormal vaginal bleeding	14	9
Genital Itching	33	10
Lesions/ sores	71	54
Lower abdominal pain	51	31
Pain during intercourse	24	10
Painful urination	51	24
Genital Warts	21	9
Urethral discharge	14	2
Loss of weight	21	22
Diarrhoea of long duration	10	12
Other	16	10
Don't know	4	3
<b>Total</b>	<b>136</b>	<b>430</b>

Most CBDs and clients knew at least one STI symptom. Table 14 shows a comparison of the knowledge of signs and symptoms of STIs among CBDs and their clients. More than a half of

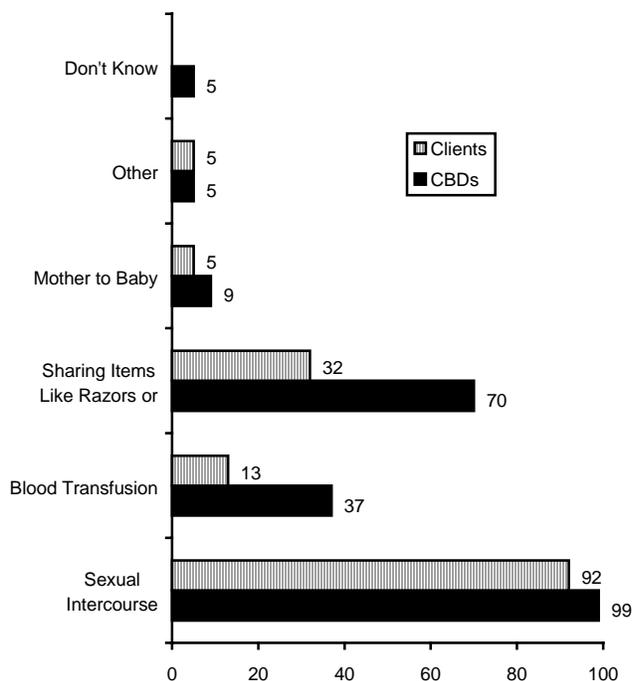
CBDs mentioned abnormal discharge, lesion/sores, lower abdominal pain and painful urination while most clients mentioned lesions/sores followed by clients who mentioned abnormal vaginal discharge.

CBD agents and their clients were asked questions to determine if they knew how HIV/AIDS was contracted and how they could protect themselves. Figure 24 shows the responses from both CBDs' and their clients.

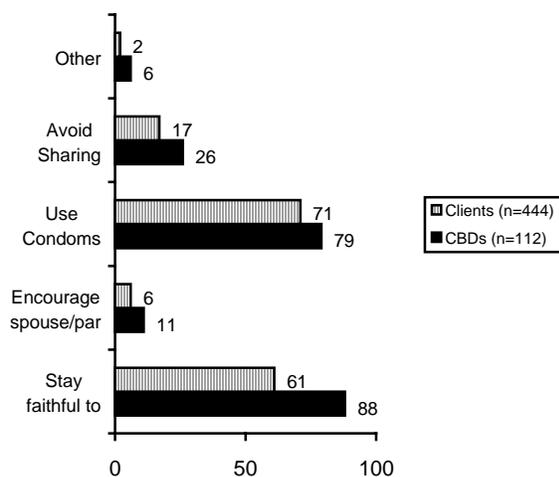
The majority of both CBDs and clients mentioned sexual intercourse as one of the ways one could contract HIV/AIDS. This was followed by CBDs who mentioned sharing of items such as razor blades and needles as a way of contracting HIV/AIDS. Other ways which people could contract HIV/AIDS were rarely mentioned/known by both CBDs and clients. Most CBDs (Figure 25) mentioned staying faithful to one spouse/partner and using condoms as ways of protection against HIV/AIDS and similarly, most clients mentioned the same ways of protection. The pattern of clients' knowledge of ways of contracting and protection of HIV/AIDS is consistent with that of CBDs. Considering the extensive contact that CBDs have with the community, they should be trained in basic STI/HIV/AIDS counseling to enable them to adequately discuss and impart knowledge on these topics.

In some communities, women use intra-vaginal preparations for different reasons; mainly to 1) enhance sexual pleasure 2) dry the vagina 3) prevent STDs or conception 4) ease child delivery. Responses from the study showed that a fairly large proportion of both female CBDs (41 percent) and clients (52 percent) had ever used vaginal preparations. There is evidence that shows a strong association between use of intra-vaginal preparations and cervicitis.<sup>14</sup> Public education on the risks associated with these practices will benefit the communities that CBDs serve.

**Figure 24: CBDs' and Clients' Knowledge of Ways of Contracting HIV/AIDS**



**Figure 25: CBDs' and Clients' Knowledge of Ways of Preventing HIV/AIDS**



<sup>14</sup> Latif, Ahmed S (1995) "A report on a Study to Determine the Aetiology and Pattern of STD amongst

## ***D ALTERNATIVE SERVICE DELIVERY SYSTEM IN THE RURAL AREAS***

The depot holder concept is one of the approaches to community based FP service delivery which the ZNFPC is still piloting in rural areas as an alternative way to the conventional CBD door to door approach.<sup>15</sup> In this model, revisit clients are expected to visit a fixed location, typically a home of a depot holder for oral contraceptive supplies. This approach was meant to provide CBDs with more time to motivate new clients and therefore spend less time on resupplying clients. Results of the 1991 ZSAS showed that the depot holder concept was an acceptable approach to both CBDs and their clients.

The 1996 ZSAS findings indicate that 42 percent of CBD clients were willing to go and obtain methods from depot holders residing within their locality. When asked whether they would be willing to go and obtain FP methods from someone outside their locality, only 24 percent of clients indicated that they were willing. This contrasts with a much lower proportion of only 14 percent of CBDs who thought that clients would be willing to obtain FP methods from a depot holder outside their locality. This shows that the depot holder model is still acceptable to rural clients and its application should be expanded in light of lessons learnt from the two pilot projects.

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*Men and Women Presenting to Health Centres in Harare, Zimbabwe, and to Determine Risk Factors for Cervicitis among Symptomatic and Asymptomatic Women. University of Zimbabwe Medical School.*

<sup>15</sup> *Not all respondents had access to depot holders since this project was piloted only in Binga and Maungwe districts in Matabeleland North and Manicaland Provinces. The depot holder project in Binga was discontinued as the nature of human settlement was found not appropriate for the depot holder model.*

## **V CHANGES IN THE FAMILY PLANNING PROGRAMME SINCE 1991**

A comparison of two Situation Analysis Surveys conducted in 1991 and 1996 shows that the family planning programme has made marked progress with respect to some indicators and regressed in others (Tables 15-18). Observations show that both clinics and CBD agents have made progress in terms of the preparedness to deliver service quality. Improvements in facility preparedness are not clearly associated with corresponding observation in service quality. A few examples illustrate the case.

Of the service providers who attended refresher training, 83 percent attended courses on FP counseling, human sexuality and communication skills. On the other hand observations of provider client interactions showed a decline in the percent of providers who inquired about reproductive goals, method side effects and their management. Nearly 60% of providers reported that they had refresher training in STI/AIDS management within three years before the survey. Nearly all facilities rely on the syndromic approach for screening for sexually transmitted infections. It is a paradox that in only a tenth of observations providers were observed to use the syndromic approach with clients. The obvious neglect of providers to discuss the condom as a method that prevents pregnancy and protects client against STIs is a glaring point. Finally, it was noted that there has been massive production of IEC material since the first Situation Analysis Study. However, it was noted that just over a tenth of providers used brochures during counseling sessions and flip charts were rarely used.

Some highlights of findings shown in the tables are outlined below.

### **Changes in Facility Preparedness**

- The 1996 survey showed that a higher proportion of health facilities had examining couches, weighing machines and specula. There was no change in availability of blood pressure machines, sterilizing equipment, uterine sound, and tenacula. Availability of equipment used during IUD examination appears to be constant since the 1997 survey.
- There is overall improvement in availability of IEC materials and the percent of health talks held at health facilities.
- The second survey showed a significant improvement in facility management and supervision. A higher percentage of health facilities were supervised more frequently and clinics had kept proper stock records.

### **Changes in Service Quality at the Health Facilities**

Results from 1996 show that providers paid attention to some quality of care elements and neglected other areas.

- There was an increase in the percentage of clients told about all methods except the condom. Between the two surveys, there was a steep drop from 39 percent to 21 percent of clients who were told about condoms during counseling sessions.

- There was a decrease in the percentage of providers who inquired about their clients' reproductive goals and breast-feeding status.
- With regard to the method given, there was an increase in the percentage of providers who discussed how the chosen method works. However, discussion of side effects and their management decreased.

### Changes in the CBD Programme

- The 1996 data showed that there was an improvement in the percentage of CBD agents who carried recommended equipment and materials for them to carry out their duties. More CBD agents carried contraceptive sample kits, procedure manuals, blood pressure machines, the stethoscopes and referral slips. However, the proportion of CBD agents who carried contraceptive instruction sheets was constant or decreased.
- A decrease of over 25 percent was noted in the percentage of CBD agents who discussed condoms with clients during counseling. Discussion of other methods by CBD agents showed a marked increase.
- The second study showed that a smaller percentage of CBD agents used IEC materials during counseling sessions.
- The second Situation Analysis Study showed a decline from 94 percent to four percent of CBD records that were judged to be clean, readable and without any torn pages.

**Table 15: Changes in the Programme Preparedness Since 1991<sup>16</sup>**

Selected Health Facility Based Indicator	% in 1991	% in 1996	Change
<b>Physical Infrastructure</b>			
Adequate water available	71	71	No change
Enough Seating Space Available	74	29	decrease
<b>Facilities with Equipment</b>			
Blood pressure machine	93	94	No change
Sterilizing Equipment	64	60	No change
Examination Couch	72	94	increase
Adult weighing scale	86	98	increase
Uterine sounds	17	16	No change
Specula	78	94	Increase
Tenacula	16	15	No change
<b>IEC activities</b>			
Health talk held at facility	15	25	Increase
FP Posters observed	55	85	Increase
<b>No. of supervisory visits six months before survey</b>			
0	42	1	Decrease
1	28	8	Decrease
2	13	18	Increase
3 and above	17	73	Increase
Facilities with proper stock keeping	62	93	Increase
Providers attended FP refresher courses	6	18	Increase

<sup>16</sup> An increase or decrease equal to or greater than 5 percent was considered to be significant.

**Table 16: Changes in the Quality of Services Offered at Health Facilities Since 1991**

<b>Selected Quality Indicator</b>	<b>% in 1991</b>	<b>% in 1996</b>	<b>Change</b>
<b>Methods mentioned to new FP clients</b>			
COC	32	35	No change
POP	56	66	Increase
Condoms	39	21	Decrease
Injectable	2	51	Increase
IUD	14	22	Increase
Norplant	0	15	Increase
Tubal ligation	6	10	No change
Vasectomy	1	3	No change
<b>Assessing Client's reproductive needs</b>			
Ask reproductive goals	64	51	Decrease
Ask breastfeeding status	83	62	Decrease
<b>Information Given on method Chosen by clients</b>			
how method works	79	93	Increase
discuss side effects	72	60	Decrease
management of side effects	75	51	Decrease

**Table 17: Changes in the CBD Programme Since 1991**

<b>Selected Indicator</b>	<b>% in 1991</b>	<b>% in 1996</b>	<b>Change</b>
<b>Equipment/Items carried by CBDs</b>			
Pill checklist	92	92	no change
Contraceptive sample kit	61	83	increase
Procedure Manual	79	80	No change
BP Machine	40	73	increase
Stethoscope	40	76	Increase
CBD Referral Slips	31	72	Increase
POP instruction sheets	86	77	Decrease
COC instruction sheets	86	75	Decrease
Condom instruction sheets	49	47	No change
<b>Supervisory Activities by Group Leaders</b>			
Visits clients with CBD	72	68	No change
Wrote comments	57	64	Increase
Assist CBD with client prob.	43	58	Increase
Check equipment	23	53	Increase
Check record book	75	65	Decrease

**Table 18: Changes in the Quality Elements for the CBD Programme Since 1991**

<b>Selected Indicator</b>	<b>% in 1991</b>	<b>% in 1996</b>	<b>Change</b>
<b>Method mentioned to clients during interactions with CBDs</b>			
COC	28	75	Increase
POP	74	75	No change
Condoms	69	42	Decrease
Injectable	Not Available	50	Increase
IUD/Loop	26	44	Increase
Norplant	Not Available	32	Increase
Tubal Ligation	7	29	Increase
Vasectomy	0	19	Increase
<b>IEC Materials Used for Counseling</b>			
Instruction sheets	58	46	Decrease
contraceptive samples	35	45	Increase
POP booklet	28	2	Decrease
Flip book	19	8	Decrease
COC green booklet	7	2	Decrease
Condom yellow booklet	7	2	Decrease

## **VI PLANNING, DISSEMINATION AND DATA INTERPRETATION WORKSHOPS**

Before the 1996 Situation Analysis Study commenced, an initial three-day planning workshop was held in Harare to review the data collection instruments developed by the Population Council. As a result, topics investigated during the 1996 Zimbabwe Situation Analysis Study reflected what was agreed upon by different groups of stakeholders. Participants to this workshop were drawn from ZNFPC, MOH&CW, Harare and Bulawayo City Health Departments.

A number of dissemination workshops were conducted after the study. The first was for ZNFPC management staff; the second was for CBDs and their supervisors. The third workshop was held at national level and was attended by heads of sectors (MOH&CW, Local Authorities, Private Sector, Donors and Cooperating Agencies) and provincial staff. Recommendations suggested by the workshop participants are included in this report.

During the months of January and February, 1998, two regional workshops were conducted for the provincial and district level staff. The two workshops, scheduled over two days were an attempt to involve staff in discussing the results of the Situation Analysis and identifying problems where programme interventions could be introduced. In each of the workshops, over 30 participants drawn from the ZNFPC, the Government and municipalities were invited.

In addition to the dissemination workshops, the Situation Analysis results have been used extensively for designing the Second ZNFPC Strategic Plan for Reproductive Health (1997 to 2002). Findings from the 1996 Situation Analysis Study provided background materials on different aspects of the program; namely service delivery, IEC and training.

## VII APPENDICES

### Appendix 1

#### Participants of the 1996 Zimbabwe Situation Analysis Planning Workshop (14<sup>th</sup> July 1996)

##### ZNFPC

Dr B Ncube  
Mr NC Kazuva  
Mrs F Chikara  
Mrs T Nhliziyo  
Mrs L Botsh  
Ms HMB Dube  
Mr A Phiri  
Mrs S Chitsungo

##### Secretarial services

Mrs S Munemo

##### Non ZNFPC

Mr L Ndhlovu  
Mrs R Rogers  
Mr Makondo  
Dr F Ndlovu  
Mrs I Moyo

### Appendix 2

#### 1996 Zimbabwe Situation Analysis Research Assistants

##### ZNFPC Staff

Mrs B Matabela  
Mrs E Chiwundo  
Mrs E Muchirahondo  
Mrs K Dlakama  
Ms E Makoni  
Ms S Sibanda  
Ms R Nheta  
Ms A Tengende  
Ms S Mwamuka  
Ms A Matinyarare  
Ms S Tasvika  
Mrs B Mhlanga  
Mrs J Muchemwa  
Mrs J Chimedza  
Mrs K Chikazhe  
Mrs E Jingura

##### Non ZNFPC Staff

Mrs C Chipeperekwa  
Ms J Hawadi  
Ms G Chigumira  
Ms N Ndlovu  
Ms N Chirimuuta  
Ms N Kawundi  
Ms A Zviringo  
Ms M Muketiwa  
Ms N Chiwoko  
Ms A Mudhaya  
Ms M Zulu  
Mr J Chigumbura  
Mr P Lunga  
Mr C Sibanda  
Mr N Mujuru  
Mr S Phiri

## Appendix 3

### 1996 Zimbabwe Situation Analysis Dissemination Workshop CBD Component Participants

#### ZNFPC Head Office

1. Mrs Marangwanda
2. Mrs Nhliziyo
3. Mrs Botsh
4. A Phiri
5. Mrs Nyakauru
6. Mrs S Chitsungo
7. Mrs Nyakwangwa
8. R Kamhuka
9. S Moyo
10. Mrs J Moyo
11. E Hluyo

#### Provinces

- |                      |  |
|----------------------|--|
| 1. B Matabela        | Service Delivery Coordinator                 |
| 2. L Ncube           | Senior Training Officer                      |
| 3. R Nheta           | Sister in-charge (Community)                 |
| 4. A Mpatsi          | Sister in-charge Community                   |
| 5. R Huni            | Sister in-charge (Community)                 |
| 6. H Mugani          | Sister in-charge (Community)                 |
| 7. I J Chirochangu   | Sister in-charge (Community)                 |
| 8. E Mudzimwa        | Sister in-charge (Community)                 |
| 9. H S Muusha        | Sister in-charge (Community)                 |
| 10. M Mugwagwa       | Clinic Nurse (Ex fieldnurse)                 |
| 11. R W Maisiri      | Clinic Sister (Ex fieldnurse)                |
| 12. J Hore           | Clinic Sister -Mobile clinic (Ex fieldnurse) |
| 13. J H Chimedza     | State Certified Nurse                        |
| 14. E Dhliwayo       | State Certified Nurse                        |
| 15. E Mudariki       | State Certified Nurse                        |
| 16. M Mukamba        | Senior Educator                              |
| 17. A Makuhwa        | Senior Educator                              |
| 18. R Chipango       | Senior Educator                              |
| 19. E J Zimwara      | Senior Educator                              |
| 20. J Chakare        | Senior Educator                              |
| 21. T Zaranyika      | Group Leader                                 |
| 22. A John           | Group Leader                                 |
| 23. E Marawa         | Group Leader                                 |
| 24. D Dzuda          | Group Leader                                 |
| 25. S Kapungu        | Group Leader                                 |
| 26. S Chinyandura    | Group Leader                                 |
| 27. L Ndhlovu        | Group Leader                                 |
| 28. E Mpofu          | Group Leader                                 |
| 29. E Dube           | Group Leader                                 |
| 30. S Samatanga      | Group Leader                                 |
| 31. R Hore           | Group Leader                                 |
| 32. A Mhungu         | Group Leader                                 |
| 33. P Vhareta        | Group Leader                                 |
| 34. K Shava          | Group Leader                                 |
| 35. A Madzivazvido   | Group Leader                                 |
| 36. Jonathan Chaibva | Group Leader                                 |

- |                 |                             |
|-----------------|-----------------------------|
| 37. R Utete     | Group Leader                |
| 38. T Pedzisayi | Community Based Distributor |
| 39. M Madiye    | Community Based Distributor |
| 40. M Katapa    | Community Based Distributor |
| 41. P Canisius  | Community Based Distributor |
| 42. T Chihwendu | Community Based Distributor |
| 43. T Nera      | Community Based Distributor |
| 44. C Masoka    | Community Based Distributor |
| 45. B Moyo      | Community Based Distributor |
| 46. S Moyo      | Community Based Distributor |
| 47. A Ndhlovu   | Community Based Distributor |
| 48. V Zinzombe  | Community Based Distributor |
| 49. D Mubiri    | Community Based Distributor |
| 50. M Chuma     | Community Based Distributor |
| 51. N Hamanda   | Community Based Distributor |

**Secretarial services**

- |                 |                     |
|-----------------|---------------------|
| 63. Mrs Sherewa | Typist/Stenographer |
|-----------------|---------------------|

## **Appendix 4**

### **National level dissemination workshop participants list (14 November 1997)**

#### **ZNFPC**

1. Dr A F Zinanga
2. Dr B Ncube
3. Dr J Kasule
4. Mr R Samkange
5. Mr NC Kazuva
6. Mrs Marangwanda
7. Mrs T Nhliziyi
8. Mrs L Botsh
9. Ms F Bopoto
10. Ms HMB Dube
11. Mr A Phiri
12. Mrs R Nyakauru
13. Ms L Ncube

#### **Non ZNFPC**

14. Dr Marindo-Ranganai
15. Dr E Xaba
16. Dr T Chaita
17. Dr Mbizvo
18. Dr K Kostermans
19. Mrs Y Zenda
20. Ms T Nheta
21. Mrs R Rogers
22. Ms I Moyo
23. Mr Sevaggio
24. Ms O E Dube
25. Mr L K Shodu
26. Ms Barbra Tobin
27. Mr M Banatat
28. Mr P Dougherty
29. Mrs Todd
30. Mrs L Lunga
31. Mrs C Musunga
32. Nr E D Masiyiwa
33. Mrs P Munyaradzi
34. Mr H K Makaupe
35. Ms B Chikukwa
36. Ms M T Nyandoro
37. Mrs E Takawira
38. Mr G V Geldermalsen
39. Mr F W Mavedzenge
40. Mr A M Senderai
41. Ms D Luke
42. Mrs T Mungate
43. Mrs I Mafethe

#### **Secretarial services**

44. Mrs P Sherewa

## Appendix 5

### Participants of the 1998 Situation Analysis Study Regional Dissemination Workshop: 25 - 26 February 1998 (Midlands, Masvingo, Matabeleland North & South Provinces)

1.	Dr A. Zinanga	Harare, ZNFPC
2.	Dr B. Ncube	Harare, ZNFPC
3.	Dr Kulkarni	Mat. South
4.	Dr A. Mthombeni	UBH
5.	Dr R. Garira	Gweru City
6.	Dr A. Hwalima	Bulawayo
7.	Dr C. Zishiri	Midlands
8.	O. Ziro	Midlands
9.	I. Nyati	Mat. North
10.	I.I. Mcingolwane	Mat. South
11.	E. Gombingo	Midlands
12.	G. Mahere	Midlands
13.	A.R. Sibanda	Midlands
14.	M. Muchetii	Mat. North
15.	A.M. Gaviro	Masvingo
16.	L.T. Kavumbura	Masvingo
17.	O.L. Dube	Mat. South
18.	R. Ncube	Mat. South
19.	A. Moyo	Mat. North
20.	I. Moyo	Mat. North
21.	F. Maveojaye	Masvingo
22.	C.M. Mahlangu	Mat. North
23.	T. Doba	Masvingo
24.	M. Mahloe	Masvingo
25.	S. Sibanda	Mat. South, Acting Provincial Manager, ZNFPC
26.	C. Maposa	Midlands
27.	S. Jhamba	Gweru City
28.	T.F. Mdlongwa	Mat. North
29.	B. Silongwe	Mat. South
30.	G. Ncube	Mat. South
31.	F. Masakadza	Masvingo
32.	C.S. Marangwanda	Harare, ZNFPC
33.	F. Mavedzenge	Masvingo
34.	HMB Dube	Harare, ZNFPC
35.	S. Simba	

## Appendix 6

### List of Participants for Manicaland, Mashonaland East, West & Central Provinces

1. Dr E. Agossou
2. Dr A. Zezai
3. Dr A. Mahomva
4. Ms. B. Benza
5. Ms. W. Bhila
6. Mr J.M. Chengeta
7. Ms Betty Chikono
8. Ms Chiwundo
9. Mrs D. Gwanzura
10. Mrs S. Hove
11. Ms Kabvunde
12. Mrs F. Kakurira
13. Mrs E. Kanengoni
14. Mrs M. Kuchenga
15. Mrs H.N. Kunaka
16. Mrs J. Kuwaza
17. Ms Mache
18. Ms J.B. Maferefa
19. Ms V. Mahati
20. Dr A. Mahomva
21. Mrs S. Makasi
22. Mrs J. Marembo
23. Ms J. Maronda
24. Mrs Matambanadzo
25. Ms L. Mbiru
26. M.T. Mukanda
27. Mr T.S. Muparutsa
28. Mrs Mutasa
29. Ms Shoko
30. Mrs Sibindi
31. Mrs S. Simba
32. Ms A. Tengende
33. Mrs A. Vinga
34. Ms Masangwi
35. Ms Mayengahama
36. Mrs R. Rogers
37. Mr. L. Ndhlovu